No. 15-274

In The Supreme Court of the United States

WHOLE WOMAN'S HEALTH ET AL. PETITIONERS

v.

KIRK COLE, M.D., COMMISSIONER OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

JOINT APPENDIX VOLUME I

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Petition For Certiorari Filed Sept. 2, 2015
Certiorari Granted Nov. 13, 2015

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United States District Court
Western District of Texas (Austin)
CIVIL DOCKET FOR CASE #: 1:14-cv-00284-LY

Whole Woman's Health et al v. Lakey et al
Assigned to: Judge Lee Yeakel
Case in other court:
USCA Fifth Circuit, 14-50928
USCA Fifth Circuit, 14-51017 (Cross-Appeal)
Cause: 28:1983 Civil Rights

Date Filed: 04/02/2014
Date Terminated: 08/29/2014
Jury Demand: None
Nature of Suit: 440 Civil Rights: Other
Jurisdiction: Federal Question

Date Filed	#	Docket Text
04/02/2014	1	COMPLAINT (Filing fee $ 400 receipt number 100020589), filed by Sherwood C. Lynn, Jr., MD, Abortion Advantage, Whole Woman's Health, Austin Woman's Health Center, Lendol L. Davis, MD, Pamela J. Richter, DO, Killeen Woman's Health Center, Lamar Robinson, MD, Nova Health Systems. (Attachments: # 1 Exhibit 1, # 2 Exhibit 2, # 3 Civil Cover Sheet /Receipt)(klw) (Entered: 04/03/2014)
04/03/2014	2	Letters to Stephanie Toti, Esha Bhandari and Natasha Lycia Ora Barman re: non-admitted status. (klw) (Entered: 04/03/2014)
04/03/2014	3	NOTICE of Attorney Appearance by Jonathan F. Mitchell on behalf

		of David Lakey, MD, Mari Robinson. Attorney Jonathan F. Mitchell added to party David Lakey, MD(pty:dft), Attorney Jonathan F. Mitchell added to party Mari Robinson(pty:dft) (Mitchell, Jonathan) (Entered: 04/03/2014)
04/03/2014	4	NOTICE of Attorney Appearance by Jan Soifer on behalf of Abortion Advantage, Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health. Attorney Jan Soifer added to party Abortion Advantage(pty:pla), Attorney Jan Soifer added to party Austin Woman's Health Center(pty:pla), Attorney Jan Soifer added to party Lendol L. Davis, MD(pty:pla), Attorney Jan Soifer added to party Killeen Woman's Health Center(pty:pla), Attorney Jan Soifer added to party Sherwood C. Lynn, Jr., MD(pty:pla), Attorney Jan Soifer added to party Nova Health Systems(pty:pla), Attorney Jan Soifer added to party Pamela J. Richter, DO(pty:pla), Attorney Jan Soifer added to party Lamar Robinson, MD(pty:pla), Attorney Jan Soifer added to party Whole

Woman's Health(pty:pla) (Soifer, Jan) (Entered: 04/03/2014)

04/03/2014 5 MOTION to Appear Pro Hac Vice by Jan Soifer *(Esha Bhandari)* (Filing fee $ 100 receipt number 0542-6377837) by on behalf of Abortion Advantage, Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health. (Attachments: # 1 Proposed Order)(Soifer, Jan) (Attachment 1 replaced on 9/3/2014) (klw). (Main Document 5 replaced on 9/3/2014) (klw). (Entered: 04/03/2014)

04/03/2014 6 MOTION to Appear Pro Hac Vice by Jan Soifer *(Stephanie Toti)* (Filing fee $ 100 receipt number 0542-6377956) by on behalf of Abortion Advantage, Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health. (Attachments: # 1 Proposed Order)(Soifer, Jan) (Attachment 1 replaced on 9/3/2014) (klw). (Main Document 6 replaced on

9/3/2014) (klw). (Entered: 04/03/2014)

04/03/2014 7 MOTION to Appear Pro Hac Vice by Jan Soifer *(John H. Bucy, II)* (Filing fee $ 100 receipt number 0542-6377983) by on behalf of Abortion Advantage, Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health. (Attachments: # 1 Proposed Order)(Soifer, Jan) (Attachment 1 replaced on 9/3/2014) (klw). (Main Document 7 replaced on 9/3/2014) (klw). (Entered: 04/03/2014)

04/03/2014 8 NOTICE of Attorney Appearance by Andrew S. Oldham on behalf of David Lakey, MD, Mari Robinson. Attorney Andrew S. Oldham added to party David Lakey, MD(pty:dft), Attorney Andrew S. Oldham added to party Mari Robinson(pty:dft) (Oldham, Andrew) (Entered: 04/03/2014)

04/03/2014 9 MOTION to Appear Pro Hac Vice by Jan Soifer *(Natasha Lycia Ora Bannan)* (Filing fee $ 100 receipt number 0542-6378011) by on behalf of Abortion Advantage, Austin Woman's Health Center,

Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health. (Attachments: # 1 Proposed Order)(Soifer, Jan) (Attachment 1 replaced on 9/3/2014) (klw). (Main Document 9 replaced on 9/3/2014) (klw). (Entered: 04/03/2014)

04/03/2014 10 MOTION for Preliminary Injunction by Abortion Advantage, Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health. (Attachments: # 1 Proposed Order)(Soifer, Jan) (Entered: 04/03/2014)

04/03/2014 11 NOTICE of Attorney Appearance by Michael P. Murphy on behalf of David Lakey, MD, Mari Robinson. Attorney Michael P. Murphy added to party David Lakey, MD(pty:dft), Attorney Michael P. Murphy added to party Mari Robinson(pty:dft) (Murphy, Michael) (Entered: 04/03/2014)

04/03/2014 12 *** **WITHDRAWN Pursuant to 32 Order** *** Amended MOTION for Preliminary Injunction by

		Abortion Advantage, Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health. (Attachments: # 1 Declaration-Miller, # 2 Declaration-Ferrigno, # 3 Declaration-Carreon, # 4 Declaration-Laster, # 5 Declaration-Fine, # 6 Declaration-Raymond, # 7 Declaration-Felix, # 8 Proposed Order)(Soifer, Jan) Modified on 4/17/2014 (klw). (Entered: 04/03/2014)
04/03/2014	13	REQUEST FOR ISSUANCE OF SUMMONS by Abortion Advantage, Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health. (Soifer, Jan) (Main Document 13 replaced on 9/3/2014) (klw). (Entered: 04/03/2014)
04/03/2014	14	REQUEST FOR ISSUANCE OF SUMMONS by Abortion Advantage, Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova

		Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health. (Soifer, Jan) (Entered: 04/03/2014)
04/03/2014	15	Memorandum in Support of 12 Amended MOTION for Preliminary Injunction by Abortion Advantage, Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health. (Attachments: # 1 Appendix)(Soifer, Jan) (Entered: 04/03/2014)
04/04/2014	16	Summons Issued as to David Escamilla, Jaime Esparza, Rene Guerra, David Lakey, MD, James E. Nichols, Susan D. Reed, Mari Robinson, Joe Shannon, Jr., Craig Watkins. (klw) (Entered: 04/04/2014)
04/08/2014	17	ORDER GRANTING 9 Motion for Natasha Lycia Ora Bannan to Appear Pro Hac Vice on behalf of Plaintiffs. Pursuant to our Administrative Policies and Procedures for Electronic Filing, the attorney hereby granted to practice pro hac vice in this case must register for electronic filing with our court within 10 days of this order.

		Signed by Judge Lee Yeakel. (klw) (Entered: 04/08/2014)
04/08/2014	18	ORDER GRANTING 6 Motion for Stephanie Toti to Appear Pro Hac Vice on behalf of Plaintiffs. Pursuant to our Administrative Policies and Procedures for Electronic Filing, the attorney hereby granted to practice pro hac vice in this case must register for electronic filing with our court within 10 days of this order. Signed by Judge Lee Yeakel. (klw) (Entered: 04/08/2014)
04/08/2014	19	ORDER GRANTING 5 Motion for Esha Bhandari to Appear Pro Hac Vice on behalf of Plaintiffs. Pursuant to our Administrative Policies and Procedures for Electronic Filing, the attorney hereby granted to practice pro hac vice in this case must register for electronic filing with our court within 10 days of this order. Signed by Judge Lee Yeakel. (klw) (Entered: 04/08/2014)
04/08/2014	20	ORDER GRANTING 7 Motion for John H. Bucy, II to Appear Pro Hac Vice on behalf of Plaintiffs. Pursuant to our Administrative Policies and Procedures for Electronic Filing, the attorney hereby granted to practice pro hac vice in this case must register for electronic filing with our court within 10 days of

		this order. Signed by Judge Lee Yeakel. (klw) (Entered: 04/08/2014)
04/08/2014	21	NOTICE of Attorney Appearance by Beth Klusmann on behalf of David Lakey, MD, Mari Robinson. Attorney Beth Klusmann added to party David Lakey, MD(pty:dft), Attorney Beth Klusmann added to party Mari Robinson(pty:dft) (Klusmann, Beth) (Entered: 04/08/2014)
04/14/2014	22	MOTION for Temporary Restraining Order by Nova Health Systems, Pamela J. Richter, DO. (Attachments: # 1 Declaration of Gerri Laster, # 2 Declaration of Stephanie Toti, # 3 Proposed Order)(Soifer, Jan) (Entered: 04/14/2014)
04/14/2014	23	Unopposed MOTION for Leave to Exceed Page Limitation by David Lakey, MD, Mari Robinson. (Attachments: # 1 Proposed Order Proposed Order Granting Motion to Exceed Page Limit, # 2 Exhibit Response in Opposition to Plaintiffs' Amended Motion for a Preliminary Injunction, # 3 Exhibit Proposed Order Denying Plaintiffs' Amended Motion for a Preliminary Injunction, # 4 Exhibit Declaration of Dr. Anderson, # 5 Exhibit Declaration of Dr. Keyes, # 6 Exhibit Declaration of Dr. Thorp, # 7

		Exhibit Declaration of Dr. Uhlenberg)(Mitchell, Jonathan) (Entered: 04/14/2014)
04/14/2014	24	Response in Opposition to Motion, filed by David Lakey, MD, Mari Robinson, re 22 MOTION for Temporary Restraining Order filed by Plaintiff Nova Health Systems, Plaintiff Pamela J. Richter, D.O. (Attachments: # 1 Proposed Order)(Mitchell, Jonathan) (Entered: 04/14/2014)
04/15/2014	25	Response in Opposition to Motion, filed by David Lakey, MD, Mari Robinson, re 12 Amended MOTION for Preliminary Injunction filed by Plaintiff Lamar Robinson, M.D., Plaintiff Nova Health Systems, Plaintiff Killeen Woman's Health Center, Plaintiff Sherwood C. Lynn, Jr., M.D., Plaintiff Lendol L. Davis, M.D., Plaintiff Whole Woman's Health, Plaintiff Austin Woman's Health Center, Plaintiff Abortion Advantage, Plaintiff Pamela J. Richter, D.O. (Attachments: # 1 Proposed Order, # 2 Appendix Dr. Anderson Declaration, # 3 Appendix Dr. Keyes Declaration, # 4 Appendix Dr. Thorpe Declaration, # 5 Appendix Dr. Uhlenberg Declaration)(Mitchell, Jonathan) (Entered: 04/15/2014)

04/15/2014	26	NOTICE of Attorney Appearance by Andrew Bowman Stephens on behalf of David Lakey, MD, Mari Robinson. Attorney Andrew Bowman Stephens added to party David Lakey, MD(pty:dft), Attorney Andrew Bowman Stephens added to party Mari Robinson(pty:dft) (Stephens, Andrew) (Entered: 04/15/2014)
04/15/2014	27	NOTICE of Attorney Appearance by Esteban San Miguel Soto on behalf of David Lakey, MD, Mari Robinson. Attorney Esteban San Miguel Soto added to party David Lakey, MD(pty:dft). (Soto, Esteban) Modified docket text on 4/15/2014 (kkc). (Entered: 04/15/2014)
04/15/2014	28	NOTICE of Attorney Appearance by James Davis Blacklock on behalf of David Lakey, MD, Mari Robinson. Attorney James Davis Blacklock added to party David Lakey, MD(pty:dft), Attorney James Davis Blacklock added to party Mari Robinson(pty:dft) (Blacklock, James) (Entered: 04/15/2014)
04/16/2014	29	MOTION *APPLICATION FOR COURT ORDER AUTHORIZING THE DISCLOSURE AND USE OF TEXAS DEPARTMENT OF STATE HEALTH SERVICES INVESTIGATION DOCUMENTS*

by David Lakey, MD, Mari Robinson. (Attachments: # 1 Proposed Order)(Blacklock, James) (Entered: 04/16/2014)

04/16/2014 30 Minute Entry for proceedings held before Judge Lee Yeakel: Motion Hearing held on 4/16/2014 re 22 MOTION for Temporary Restraining Order filed by Nova Health Systems, Pamela J. Richter, D.O. Motion ruled on—written order to follow. (Minute entry documents are not available electronically.). (Court Reporter Arlin& Rodirguez.)(klw) (Entered: 04/16/2014)

04/17/2014 31 ORDER GRANTING State Defendants' 23 Motion for Leave to File Excess Pages in Response to Plaintiffs' Motion for Preliminary Injunction. Signed by Judge Lee Yeakel. (klw) (Entered: 04/17/2014)

04/17/2014 32 ORDER DENYING Plaintiffs' 22 Motion for TRO; WITHDRAWING Plaintiff's 12 Amended Motion for Preliminary Injunction. Signed by Judge Lee Yeakel. (klw) (Entered: 04/17/2014)

04/21/2014 33 SUMMONS Returned Executed by Sherwood C. Lynn, Jr., MD, Abortion Advantage, Whole Woman's Health, Austin Woman's Health Center, Lendol L. Davis,

		MD, Pamela J. Richter, DO, Killeen Woman's Health Center, Lamar Robinson, MD, Nova Health Systems. David Escamilla served on 4/15/2014, answer due 5/6/2014. (Soifer, Jan) (Entered: 04/21/2014)
04/21/2014	34	SUMMONS Returned Executed by Sherwood C. Lynn, Jr., MD, Abortion Advantage, Whole Woman's Health, Austin Woman's Health Center, Lendol L. Davis, MD, Pamela J. Richter, DO, Killeen Woman's Health Center, Lamar Robinson, MD, Nova Health Systems. David Lakey, MD served on 4/16/2014, answer due 5/7/2014. (Soifer, Jan) (Entered: 04/21/2014)
04/21/2014	35	SUMMONS Returned Executed by Sherwood C. Lynn, Jr., MD, Abortion Advantage, Whole Woman's Health, Austin Woman's Health Center, Lendol L. Davis, MD, Pamela J. Richter, DO, Killeen Woman's Health Center, Lamar Robinson, MD, Nova Health Systems. Mari Robinson served on 4/14/2014, answer due 5/5/2014. (Soifer, Jan) (Entered: 04/21/2014)
04/21/2014	36	SUMMONS Returned Executed by Sherwood C. Lynn, Jr., MD, Abortion Advantage, Whole Woman's Health, Austin Woman's Health Center, Lendol L. Davis, MD, Pamela J. Richter, DO, Killeen

		Woman's Health Center, Lamar Robinson, MD, Nova Health Systems. Susan D. Reed served on 4/15/2014, answer due 5/6/2014. (Soifer, Jan) (Entered: 04/21/2014)
04/21/2014	37	SUMMONS Returned Executed by Sherwood C. Lynn, Jr., MD, Abortion Advantage, Whole Woman's Health, Austin Woman's Health Center, Lendol L. Davis, MD, Pamela J. Richter, DO, Killeen Woman's Health Center, Lamar Robinson, MD, Nova Health Systems. James E. Nichols served on 4/16/2014, answer due 5/7/2014. (Soifer, Jan) (Entered: 04/21/2014)
04/22/2014	38	Minute Entry for proceedings held before Judge Lee Yeakel: Telephone Conference in Chambers held on 4/22/2014. Court settings announced. Written order forthcoming. (Minute entry documents are not available electronically.). (Court Reporter Arlinda Rodriguez.)(klw) (Entered: 04/22/2014)
04/23/2014	39	NOTICE *of Withdrawal of State Defendants Application* by David Lakey, MD, Mari Robinson re 29 MOTION *APPLICATION FOR COURT ORDER AUTHORIZING THE DISCLOSURE AND USE OF TEXAS DEPARTMENT OF STATE HEALTH SERVICES INVESTIGATION DOCUMENTS*

(Blacklock, James) (Entered: 04/23/2014)

04/23/2014 40 Proposed Pretrial Order *(Agreed)* by Abortion Advantage, Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health. (Toti, Stephanie) (Entered: 04/23/2014)

04/24/2014 41 NOTICE of Attorney Appearance by Enrique M. Varela on behalf of David Lakey, MD, Mari Robinson. Attorney Enrique M. Varela added to party David Lakey, MD(pty:dft), Attorney Enrique M. Varela added to party Mari Robinson(pty:dft) (Varela, Enrique) (Entered: 04/24/2014)

04/28/2014 42 SUMMONS Returned Executed by Sherwood C. Lynn, Jr., MD, Abortion Advantage, Whole Woman's Health, Austin Woman's Health Center, Lendol L. Davis, MD, Pamela J. Richter, DO, Killeen Woman's Health Center, Lamar Robinson, MD, Nova Health Systems. Jaime Esparza served on 4/16/2014, answer due 5/7/2014. (Soifer, Jan) (Entered: 04/28/2014)

04/28/2014	43	SUMMONS Returned Executed by Sherwood C. Lynn, Jr., MD, Abortion Advantage, Whole Woman's Health, Austin Woman's Health Center, Lendol L. Davis, MD, Pamela J. Richter, DO, Killeen Woman's Health Center, Lamar Robinson, MD, Nova Health Systems. Craig Watkins served on 4/22/2014, answer due 5/13/2014. (Soifer, Jan) (Entered: 04/28/2014)
04/28/2014	44	SUMMONS Returned Executed by Sherwood C. Lynn, Jr., MD, Abortion Advantage, Whole Woman's Health, Austin Woman's Health Center, Lendol L. Davis, MD, Pamela J. Richter, DO, Killeen Woman's Health Center, Lamar Robinson, MD, Nova Health Systems. Rene Guerra served on 4/17/2014, answer due 5/8/2014. (Soifer, Jan) (Entered: 04/28/2014)
04/28/2014	45	SUMMONS Returned Executed by Sherwood C. Lynn, Jr., MD, Abortion Advantage, Whole Woman's Health, Austin Woman's Health Center, Lendol L. Davis, MD, Pamela J. Richter, DO, Killeen Woman's Health Center, Lamar Robinson, MD, Nova Health Systems. Joe Shannon, Jr. served on 4/22/2014, answer due 5/13/2014. (Soifer, Jan) (Entered: 04/28/2014)

04/28/2014	46	SCHEDULING ORDER: Amended Pleadings due by 4/28/2014, Discovery due by 7/21/2014, Joinder of Parties due by 4/28/2014, Dispositive Motions due by 7/28/2014. Pretrial Conference set for 8/1/2014 09:30 AM before Judge Lee Yeakel, Jury Selection / Trial set for 8/4/2014 09:00 AM before Judge Lee Yeakel. Signed by Judge Lee Yeakel. (klw) Modified on 4/29/2014 to correct filed date (klw). (Entered: 04/29/2014)
05/02/2014	47	Transcript filed of Proceedings held on April 16, 2014, Proceedings Transcribed: Oral Argument on Plaintiffs' Motions for Temporary Retraining Order. Court Reporter/ Transcriber: Arlinda Rodriguez, Telephone number: 512-391-8791. Parties are notified of their duty to review the transcript to ensure compliance with the FRCP 5.2(a)/FRCrP 49.1(a). A copy may be purchased from the court reporter or viewed at the clerk's office public terminal. If redaction is necessary, a Notice of Redaction Request must be filed within 21 days. If no such Notice is filed, the transcript will be made available via PACER without redaction after 90 calendar days. The clerk will mail a copy of this notice to parties not electronically noticed Redaction

		Request due 5/23/2014, Redacted Transcript Deadline set for 6/2/2014, Release of Transcript Restriction set for 7/31/2014, (Rodriguez, Arlinda) (Entered: 05/02/2014)
05/02/2014	48	Motion to Dismiss for Failure to State a Claim by David Lakey, MD, Mari Robinson. (Attachments: # 1 Proposed Order)(Mitchell, Jonathan) (Entered: 05/02/2014)
05/05/2014	49	Joint MOTION to Dismiss *Joint Motion to Dismiss the Local Prosecutor Defendants* by David Escamilla, Jaime Esparza, Rene Guerra, James E. Nichols, Susan D. Reed, Joe Shannon, Jr., Craig Watkins. (Thomas, Sherine) (Entered: 05/05/2014)
05/06/2014	50	MOTION to Appear Pro Hac Vice by Jan Soifer *J. Alexander Lawrence* (Filing fee $ 100 receipt number 0542-6466550) by on behalf of Abortion Advantage, Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health. (Attachments: # 1 Proposed Order)(Soifer, Jan) (Entered: 05/06/2014)

05/06/2014	51	MOTION to Appear Pro Hac Vice by Jan Soifer *Betre M Gizaw* (Filing fee $ 100 receipt number 0542-6466590) by on behalf of Abortion Advantage, Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health. (Attachments: # 1 Proposed Order)(Soifer, Jan) (Entered: 05/06/2014)
05/12/2014	52	ORDER GRANTING 50 Motion for J. Alexander Lawrence to Appear Pro Hac Vice. Pursuant to our Administrative Policies and Procedures for Electronic Filing, the attorney hereby granted to practice pro hac vice in this case must register for electronic filing with our court within 10 days of this order. Signed by Judge Lee Yeakel. (kkc) (Entered: 05/12/2014)
05/12/2014	53	ORDER GRANTING 51 Motion for Betre M. Gizaw to Appear Pro Hac Vice. Pursuant to our Administrative Policies and Procedures for Electronic Filing, the attorney hereby granted to practice pro hac vice in this case must register for electronic filing with our court within 10 days of this order.

		Signed by Judge Lee Yeakel. (kkc) (Entered: 05/12/2014)
05/12/2014	54	ORDER GRANTING 49 Motion to Dismiss Local Prosecutor Defendants. Terminated party Rene Guerra, James E. Nichols, Susan D. Reed, Joe Shannon, Jr., Craig Watkins, David Escamilla and Jaime Esparza. Signed by Judge Lee Yeakel. (kkc) (Entered: 05/12/2014)
05/13/2014	55	MOTION *REQUESTING ELECTRONIC NOTIFICATIONS* by Evan Stone. (Attachments: # 1 Exhibit Screenshot of Northern District ECF Interface, # 2 Exhibit Declaration of Evan Stone, # 3 Proposed Order)(Stone, Evan) (Entered: 05/13/2014)
05/13/2014	56	ORDER modifying the case style pursuant to reflect the removal of recently dismissed parties. Signed by Judge Lee Yeakel. (klw) (Entered: 05/13/2014)
05/19/2014	57	Memorandum in Opposition to Motion, filed by Abortion Advantage, Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health, re 48 Motion to

		Dismiss for Failure to State a Claim filed by Defendant Mari Robinson, Defendant David Lakey, M.D. (Lawrence, J.) (Entered: 05/19/2014)
05/22/2014	58	MOTION to Quash *Subpoena and Motion for Fees* by Aaron Family Planning. (Attachments: # 1 Proposed Order Proposed Order, # 2 Exhibit Exhibit A)(Lewis, Chip) (Entered: 05/22/2014)
05/27/2014	59	Unopposed MOTION for Leave to Exceed Page Limitation by David Lakey, MD, Mari Robinson. (Attachments: # 1 Proposed Order, # 2 Defendants' Reply Brief)(Mitchell, Jonathan) (Entered: 05/27/2014)
05/28/2014	60	Joint MOTION for Protective Order by Abortion Advantage, Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health. (Attachments: # 1 Exhibit 1, # 2 Proposed Order)(Toti, Stephanie) (Entered: 05/28/2014)
05/28/2014	61	Joint MOTION for Disclosure by Abortion Advantage, Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn,

		Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health. (Attachments: # 1 Proposed Order)(Toti, Stephanie) (Entered: 05/28/2014)
05/29/2014	62	ORDER GRANTING Defendants' 59 Motion for Leave to File Excess Pages in filing of Reply Brief Supporting Defendants' 48 Motion to Dismiss. Signed by Judge Lee Yeakel. (klw) (Entered: 05/29/2014)
05/29/2014	63	Defentant's REPLY Brief in Support of their 48 Motion to Dismiss for Failure to State a Claim. (klw) (Entered: 05/29/2014)
05/30/2014	64	ORDER GRANTING Joint 61 Motion authorizing the disclosure and use of abortion-related docments, information and data. Signed by Judge Lee Yeakel. (klw) (Entered: 05/30/2014)
05/30/2014	65	CONFIDENTIALITY and PROTECTIVE ORDER. Signed by Judge Lee Yeakel. (klw) (Entered: 05/30/2014)
05/30/2014	66	RESPONSE to Motion, filed by David Lakey, MD, Mari Robinson, re 58 MOTION to Quash Subpoena and Motion for Fees filed by Neutral Aaron Family Planning (Attachments: # 1 Exhibit A, # 2

Exhibit B, # 3 Exhibit C)(Stephens, Andrew) (Entered: 05/30/2014)

05/30/2014 67 DEFICIENCY NOTICE Andrew Bowman Stephens: re 66 Response to Motion. **Pursuant to the Administrative Policies and Procedures, Proposed Orders are Required when a Response to a Motion is filed. DO NOT RE-FILE the entire document. Please, file ONLY the Proposed Order. Use the "ATTACHMENT" event from the menu and LINK the Proposed Order to your Response. In the Docket Text, type "(Proposed Order)".** (klw) (Entered: 05/30/2014)

05/30/2014 68 ATTACHMENT *Proposed Order* to 66 Response to Motion, by David Lakey, MD, Mari Robinson. (Stephens, Andrew) (Entered: 05/30/2014)

06/02/2014 69 ORDER REFERRING MOTION: 58 MOTION to Quash *Subpoena and Motion for Fees* filed by Aaron Family Planning. Signed by Judge Lee Yeakel. Referral Magistrate Judge: Andrew W. Austin. (klw) (Entered: 06/02/2014)

06/02/2014 70 ORDER for the parties to conference re 58 MOTION to Quash no later than 06/06/14. Movant to file an Advisory by noon on 6/9/2014.

		Signed by Judge Andrew W. Austin. (klw) (Entered: 06/02/2014)
06/03/2014	71	NOTICE of Voluntary Dismissal by Abortion Advantage, Lamar Robinson, MD (Toti, Stephanie) (Entered: 06/03/2014)
06/05/2014	72	ORDER that the clerk and the parties in this case use the style in this Orderfor all future pleadings in this case (Abortion Advantage and Lamar Robinson, MD terminated). Signed by Judge Lee Yeakel. (kkc) (Entered: 06/05/2014)
06/06/2014	73	ADVISORY TO THE COURT by Aaron Family Planning. (Lewis, Chip) (Entered: 06/06/2014)
06/11/2014	74	MOTION *to Modify* re 65 Protective Order, 64 Order on Motion for Disclosure by Planned Parenthood Center for Choice, Planned Parenthood of Greater Texas Surgical Health Services, Planned Parenthood South Texas Surgical Center. (Attachments: # 1 Exhibit A, # 2 Exhibit B, # 3 Exhibit C, # 4 Exhibit D, # 5 Exhibit E, # 6 Proposed Order)(O'Brien, Patrick) (Entered: 06/11/2014)
06/13/2014	75	MOTION for Miranda H. Turner to Appear Pro Hac Vice by Adriana Cecilia Pinon (Filing fee $ 100 receipt number 0542-6576641) by on behalf of Southwestern Women's

		Surgery Center. (Pinon, Adriana) Modified on 6/16/2014 (kkc). (Entered: 06/13/2014)
06/13/2014	76	NOTICE by Southwestern Women's Surgery Center, Routh Street Women's Clinic *of Filing in Support of Planned Parenthood's Motion to Modify* re 74 MOTION *to Modify* re 65 Protective Order, 64 Order on Motion for Disclosure. (Pinon, Adriana) Modified on 6/16/2014 (kkc). (Entered: 06/13/2014)
06/16/2014	77	Response in Opposition to Motion, filed by David Lakey, MD, Mari Robinson, re 74 MOTION *to Modify* re 65 Protective Order, 64 Order on Motion for Disclosure filed by Movant Planned Parenthood of Greater Texas Surgical Health Services, Movant Planned Parenthood Center for Choice, Movant Planned Parenthood South Texas Surgical Center (Murphy, Michael) (Entered: 06/16/2014)
06/16/2014	78	ATTACHMENT to 77 Response in Opposition to Motion, by David Lakey, MD, Mari Robinson. (Murphy, Michael) (Entered: 06/16/2014)
06/16/2014	79	Minute Entry for proceedings held before Judge Lee Yeakel: Telephone Conference held on 6/16/2014. Discussion heard re: protective order. (Minute entry documents

		are not available electronically.). (Court Reporter Arlinda Rodriguez.)(klw) (Entered: 06/17/2014)
06/16/2014	80	ORDER GRANTING 75 Motion for Miranda Turner to Appear Pro Hac Vice on behalf of Southwestern Woman's Surgery Center. Pursuant to our Administrative Policies and Procedures for Electronic Filing, the attorney hereby granted to practice pro hac vice in this case must register for electronic filing with our court within 10 days of this order. Signed by Judge Lee Yeakel. (klw) (Entered: 06/17/2014)
06/17/2014	81	MOTION for Helene T. Krasnoff to Appear Pro Hac Vice (Filing fee $ 100 receipt number 100021317) by Planned Parenthood Center for Choice, Planned Parenthood South Texas Surgical Center, Planned Parenthood of Greater Texas Surgical Health Services. (klw) (Entered: 06/17/2014)
06/18/2014	82	ORDER DENYING as MOOT Non-Party Aaron Family Planning's 58 Motion to Quash and Motion for Fees. Signed by Judge Andrew W. Austin. (klw) (Entered: 06/18/2014)
06/18/2014		Motions No Longer Referred: 58 MOTION to Quash *Subpoena and Motion for Fees*. (klw) (Entered: 06/18/2014)

06/18/2014	83	MOTION to Compel *Southwestern Surgery Center Production of Subpoenaed Documents* by David Lakey, MD, Mari Robinson. (Attachments: # 1 Exhibit A—Affidavit of Service, # 2 Exhibit B—SWSC Response, # 3 Proposed Order)(Stephens, Andrew) (Entered: 06/18/2014)
06/18/2014	84	ORDER GRANTING 81 Motion for Helene T. Krasnoff to Appear Pro Hac Vice on behalf of non-parties Planned Parenthood Center for Choice, PlannedParenthood of Greater Texas Surgical Health Services, and Planned Parenthood South Texas Surgical Center. Pursuant to our Administrative Policies and Procedures for Electronic Filing, the attorney hereby granted to practice pro hac vice in this case must register for electronic filing with our court within 10 days of this order. Signed by Judge Lee Yeakel. (klw) (Entered: 06/18/2014)
06/18/2014	85	ORDER REFERRING MOTION: 83 MOTION to Compel *Southwestern Surgery Center Production of Subpoenaed Documents* filed by Mari Robinson, David Lakey, M.D.. Signed by Judge Lee Yeakel. Referral Magistrate Judge: Andrew W. Austin. (klw) (Entered: 06/19/2014)

06/19/2014	86	ORDER delaying ruling on Defendants' 83 MOTION to Compel *Southwestern Surgery Center Production of Subpoenaed Documents* filed by Mari Robinson, David Lakey, M.D. until the lapse of the seven day time period pursuant to Local Rule CV-7(e)(2) to allow parties time to respond. Signed by Judge Andrew W. Austin. (klw) (Entered: 06/19/2014)
06/20/2014	87	AMENDED CONFIDENTIALITY AND PROTECTIVE ORDER. Signed by Judge Lee Yeakel. (klw) (Entered: 06/20/2014)
06/20/2014	88	Amended ORDER Granting Joint Motion for Order authorizing the dislosure and use of abortion-related documents, information and data. Signed by Judge Lee Yeakel. (klw) (Entered: 06/20/2014)
06/25/2014	89	RESPONSE to Motion, filed by Southwestern Women's Surgery Center, re 83 MOTION to Compel *Southwestern Surgery Center Production of Subpoenaed Documents* filed by Defendant Mari Robinson, Defendant David Lakey, M.D. (Attachments: # 1 Exhibit A, # 2 Exhibit B, # 3 Exhibit C)(Turner, Miranda) (Entered: 06/25/2014)
06/25/2014	90	DEFICIENCY NOTICE to Miranda Turner: re 89 Response to Motion.

		Pursuant to the Administrative Policies and Procedures, Proposed Orders are Required when a Response to a Motion is filed. DO NOT RE-FILE the entire document. Please, file ONLY the Proposed Order. Use the "ATTACHMENT" event from the menu and LINK the Proposed Order to your Response. In the Docket Text, type "(Proposed Order)". (klw) (Entered: 06/25/2014)
06/25/2014	91	ATTACHMENT *Proposed Order* to 89 Response to Motion, by Southwestern Women's Surgery Center. (Turner, Miranda) (Entered: 06/25/2014)
06/26/2014	92	ORDER Setting Hearing on 83 MOTION to Compel: Motion Hearing set for 7/1/2014 10:00 AM before Judge Andrew W. Austin. Signed by Judge Andrew W. Austin. (klw) (Entered: 06/26/2014)
07/01/2014	93	MOTION to Appear Pro Hac Vice by Stephanie Toti *(David Brown) (Filing fee $ 100 receipt number 0542-6621270)* by on behalf of Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health.

(Attachments: # 1 Proposed Order)(Toti, Stephanie) Modified on 7/1/2014 to add rect number (klw). (Entered: 07/01/2014)

07/01/2014 94 Minute Entry for proceedings held before Judge Andrew W. Austin: Motion Hearing held on 7/1/2014 re 83 MOTION to Compel *Southwestern Surgery Center Production of Subpoenaed Documents* filed by Mari Robinson, David Lakey, M.D. Motion taken under advisement. Written order to follow. (Minute entry documents are not available electronically.). (Court Reporter ERO.)(klw) (Entered: 07/01/2014)

07/01/2014 95 MOTION to Appear Pro Hac Vice by J. Alexander Lawrence *(Colin M O'Brien)* (Filing fee $ 100 receipt number 0542-6621759) by on behalf of Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health. (Attachments: # 1 Proposed Order)(Lawrence, J.) (Entered: 07/01/2014)

07/01/2014 96 MOTION to Appear Pro Hac Vice by J. Alexander Lawrence *(Marissa P. Harris)* (Filing fee $ 100 receipt number 0542-6621809) by on behalf of Austin Woman's Health

		Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health. (Attachments: # 1 Proposed Order)(Lawrence, J.) (Entered: 07/01/2014)
07/02/2014	97	ORDER GRANTING 96 Motion for Marissa P. Harris to Appear Pro Hac Vice on behalf of Plaintiffs. Pursuant to our Administrative Policies and Procedures for Electronic Filing, the attorney hereby granted to practice pro hac vice in this case must register for electronic filing with our court within 10 days of this order. Signed by Judge Lee Yeakel. (klw) (Entered: 07/02/2014)
07/02/2014	98	ORDER GRANTING 93 Motion for David P. Brown to Appear Pro Hac Vice on behalf of Plaintiffs. Pursuant to our Administrative Policies and Procedures for Electronic Filing, the attorney hereby granted to practice pro hac vice in this case must register for electronic filing with our court within 10 days of this order. Signed by Judge Lee Yeakel. (klw) (Entered: 07/02/2014)
07/02/2014	99	ORDER GRANTING 95 Motion for Colin M. O'Brien to Appear Pro Hac Vice on behalf of Plaintiffs.

		Pursuant to our Administrative Policies and Procedures for Electronic Filing, the attorney hereby granted to practice pro hac vice in this case must register for electronic filing with our court within 10 days of this order. Signed by Judge Lee Yeakel. (klw) (Entered: 07/02/2014)
07/03/2014	100	MOTION to Appear Pro Hac Vice by Stephanie Toti *(Janet Crepps)* (Filing fee $ 100 receipt number 0542-6630869) by on behalf of Abortion Advantage, Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health. (Attachments: # 1 Proposed Order)(Toti, Stephanie) (Entered: 07/03/2014)
07/07/2014	101	ORDER GRANTING IN PART AND DENYING IN PART State Defendants' 83 Motion to Compel Production of Subpoenaed Documents. SWSC shall provide the declaration described herein no later than 07/14/14. Signed by Judge Andrew W. Austin. (klw) (Entered: 07/07/2014)
07/07/2014		Motions No Longer Referred: 83 MOTION to Compel *Southwestern*

		Surgery Center Production of Subpoenaed Documents. (klw) (Entered: 07/07/2014)
07/07/2014	102	ORDER GRANTING 100 Motion for Janet Crepps to Appear Pro Hac Vice on behalf of plaintiffs. Pursuant to our Administrative Policies and Procedures for Electronic Filing, the attorney hereby granted to practice pro hac vice in this case must register for electronic filing with our court within 10 days of this order. Signed by Judge Lee Yeakel. (klw) (Entered: 07/07/2014)
07/08/2014	103	Minute Entry for proceedings held before Judge Lee Yeakel: Conference Call in Chambers held on 7/8/2014 (Minute entry documents are not available electronically.). (Court Reporter Arlinda Rodriguez.) (kkc) (Entered: 07/09/2014)
07/16/2014	104	MOTION to Appear Pro Hac Vice by J. Alexander Lawrence *(Kiersten A. Fletcher)* (Filing fee $ 100 receipt number 0542-6660175) by on behalf of Abortion Advantage, Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health. (Attachments: # 1

Proposed Order)(Lawrence, J.) (Entered: 07/16/2014)

07/17/2014 105 ORDER GRANTING 104 Motion for Kiersten A. Fletcher to Appear Pro Hac Vice on behalf of Plaintiffs. Pursuant to our Administrative Policies and Procedures for Electronic Filing, the attorney hereby granted to practice pro hac vice in this case must register for electronic filing with our court within 10 days of this order. Signed by Judge Lee Yeakel. (klw) (Entered: 07/17/2014)

07/18/2014 106 MOTION for Protective Order by South Texas Health Systems, LLC Non-Party. (Attachments: # 1 Exhibit Exhibit)(Castillo, Edward) (Entered: 07/18/2014)

07/18/2014 107 DEFICIENCY NOTICE to Edward J. Castillo: re 106 MOTION for Protective Order. **Proposed Orders are Required when a non-dispositive Motion (or Amended Motion) is filed. DO NOT RE-FILE the entire document. Please, file ONLY the Proposed Order. Use the "ATTACHMENT" event from the menu and LINK the Proposed Order to your Motion. In the Docket Text, type "(Proposed Order)".** (klw) (Entered: 07/18/2014)

07/21/2014	108	ORDER REFERRING MOTION: 106 MOTION for Protective Order filed by South Texas Health Systems, Non-Party. Signed by Judge Lee Yeakel. Referral Magistrate Judge: Andrew W. Austin. (klw) (Entered: 07/21/2014)
07/22/2014	109	Response in Opposition to Motion, filed by Abortion Advantage, Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health, re 106 MOTION for Protective Order filed by Neutral South Texas Health Systems, Non-Party (Attachments: # 1 Exhibit A: Affidavit of Service)(Toti, Stephanie) (Entered: 07/22/2014)
07/23/2014	110	ATTACHMENT *Proposed Order* to 106 MOTION for Protective Order by South Texas Health Systems, Non-Party. (Castillo, Edward) Modified docket text on 7/23/2014 (kkc). (Entered: 07/23/2014)
07/24/2014	111	ORDER DENYING non-party South Texas Health Systems, LLC's 106 Motion for Protection from Subpoena. Signed by Judge Andrew W. Austin. (klw) (Entered: 07/24/2014)

07/24/2014		Motions No Longer Referred: 106 MOTION for Protective Order. (klw) (Entered: 07/24/2014)
07/24/2014	112	NOTICE *Letter to Judge Yeakel* by David Lakey, MD, Mari Robinson (Stephens, Andrew) (Entered: 07/24/2014)
07/24/2014	113	NOTICE *; Letter to Judge Yeakel* by Abortion Advantage, Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health re 112 Notice (Other) (Lawrence, J.) (Entered: 07/24/2014)
07/24/2014	114	Minute Entry for proceedings held before Judge Andrew W. Austin: Telephone Conference held on 7/24/2014 re: Deposition Dispute. Dispute resolved by Court. (Minute entry documents are not available electronically.). (Court Reporter ERO.)(klw) (Entered: 07/25/2014)
07/28/2014	115	MOTION to Compel *Disclosure of Written Communications Between Vincent Rue and Defendants' Experts (redacted)* by Abortion Advantage, Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center,

Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health. (Attachments: # 1 Exhibit A, # 2 Exhibit B, # 3 Proposed Order)(Toti, Stephanie) (Entered: 07/28/2014)

07/28/2014 116 *** **FILING ERROR—EXHIBITS NOT ATTACHED. MOTION &ALL EXHIBITS RE-FILED AS DOCKET ENTRY NO.** 123 *** MOTION to Exclude *Rebuttal Testimony by Mayra Thompson, M.D.* by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health. (Toti, Stephanie) Modified docket text on 7/30/2014 (kkc). (Entered: 07/28/2014)

07/29/2014 117 ORDER REFERRING MOTION: 115 MOTION to Compel *Disclosure of Written Communications Between Vincent Rue and Defendants' Experts (redacted).* Signed by Judge Lee Yeakel. Referral Magistrate Judge: Andrew W. Austin. (kkc) (Entered: 07/29/2014)

07/29/2014 118 ORDER that State Defendants' file their response to Plaintiffs' 115 Motion to Compel by 5:00 p.m. Central Time on Wednesday,

July 30, 2014. Signed by Judge Andrew W. Austin. (kkc) (Entered: 07/29/2014)

07/29/2014 119 MOTION to Compel *Responses to Interrogatories* by Abortion Advantage, Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health. (Attachments: # 1 Exhibit A, # 2 Exhibit B, # 3 Exhibit C, # 4 Exhibit D, # 5 Exhibit E, # 6 Exhibit F, # 7 Exhibit G, # 8 Exhibit H, # 9 Exhibit I)(Toti, Stephanie) (Entered: 07/29/2014)

07/29/2014 120 MOTION to Exclude *Kristine Hopkins, PH.D* by David Lakey, MD, Mari Robinson. (Attachments: # 1 Exhibit Expert Report, # 2 Exhibit Deposition Transcript)(Soto, Esteban) (Entered: 07/29/2014)

07/30/2014 121 ATTACHMENT *Proposed Order* to 120 MOTION to Exclude *Kristine Hopkins, PH.D* by David Lakey, MD, Mari Robinson. (Soto, Esteban) Modified docket text on 7/30/2014 (kkc). (Entered: 07/30/2014)

07/30/2014 122 ORDER REFERRING MOTION: 119 MOTION to Compel Responses to Interrogatories. Signed by Judge Lee Yeakel. Referral Magistrate

Judge: Andrew W. Austin. (kkc)
(Entered: 07/30/2014)

07/30/2014 123 MOTION to Exclude *Rebuttal Testimony by Mayra Thompson* by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health. (Attachments: # 1 Exhibit Exhibit A—Part 1 of 2, # 2 Exhibit Exhibit A—Part 2 of 2, # 3 Exhibit Exhibit B, # 4 Exhibit Exhibit C, # 5 Exhibit Exhibit D)(Toti, Stephanie) (Entered: 07/30/2014)

07/30/2014 124 RESPONSE to Motion, filed by David Lakey, MD, Mari Robinson, re 115 MOTION to Compel *Disclosure of Written Communications Between Vincent Rue and Defendants' Experts (redacted)* filed by Plaintiff Lamar Robinson, M.D., Plaintiff Nova Health Systems, Plaintiff Killeen Woman's Health Center, Plaintiff Sherwood C. Lynn, Jr., M.D., Plaintiff Lendol L. Davis, M.D., Plaintiff Whole Woman's Health, Plaintiff Austin Woman's Health Center, Plaintiff Abortion Advantage, Plaintiff Pamela J. Richter, D.O. (Attachments: # 1 Exhibit, # 2 Proposed

Order)(Murphy, Michael) (Entered: 07/30/2014)

07/30/2014 125 ORDER Setting Hearing on 115 MOTION to Compel Disclosure of Written Communications Between Vincent Rue and Defendants' Experts, 119 MOTION to Compel Responses to Interrogatories: Motion Hearing set for 7/31/2014 at 3:00 PM before Judge Andrew W. Austin. Response to 119 MOTION to Compel Responses to Interrogatories due by 12:00 p.m. Central Time on 7/31/2014. Signed by Judge Andrew W. Austin. (kkc) (Entered: 07/30/2014)

07/30/2014 126 MOTION to Appear Pro Hac Vice by Patrick Gregory O'Brien *on behalf of Melissa Cohen* (Filing fee $ 100 receipt number 0542-6700527) by on behalf of Planned Parenthood Center for Choice, Planned Parenthood South Texas Surgical Center, Planned Parenthood of Greater Texas Surgical Health Services. (Attachments: # 1 Proposed Order)(O'Brien, Patrick) (Entered: 07/30/2014)

07/30/2014 127 MOTION in Limine *to Exclude Evidence Pertaining to the Availability of Abortion Services Outside of the State of Texas* by Abortion Advantage, Austin Woman's Health

		Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Lamar Robinson, MD, Whole Woman's Health. (Attachments: # 1 Exhibit A)(Toti, Stephanie) (Entered: 07/30/2014)
07/30/2014	128	Motion for leave to File Sealed Document (Attachments: # 1 Sealed Document, # 2 Sealed Document, # 3 Sealed Document) (Toti, Stephanie) (Entered: 07/30/2014)
07/30/2014	129	Witness List by David Lakey, MD, Mari Robinson. (Soto, Esteban) (Entered: 07/30/2014)
07/30/2014	130	Exhibit List by David Lakey, MD, Mari Robinson.. (Attachments: # 1 State Defendants' Deposition Witness List and Designation of Testimony to be Offered)(Soto, Esteban) (Entered: 07/30/2014)
07/30/2014	131	Exhibit List by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health.. (Toti, Stephanie) (Entered: 07/30/2014)
07/30/2014	132	Witness List by Austin Woman's Health Center, Killeen Woman's

		Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health. (Toti, Stephanie) (Entered: 07/30/2014)
07/30/2014	133	Proposed Findings of Fact by David Lakey, MD, Mari Robinson. (Soto, Esteban) (Entered: 07/30/2014)
07/30/2014	134	07/30/2014134 NOTICE *; Plaintiffs' Deposition Designations* by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health (Toti, Stephanie) (Entered: 07/30/2014)
07/31/2014	135	MOTION in Limine *to Exclude Irrelevant Testimony* by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health. (Attachments: # 1 Exhibit A, # 2 Exhibit B)(Toti, Stephanie) (Entered: 07/31/2014)
07/31/2014	136	Proposed Findings of Fact by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO,

		Whole Woman's Health. (Toti, Stephanie) (Entered: 07/31/2014)
07/31/2014	137	REPLY to RESPONSE in Support, filed by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health, re 115 MOTION to Compel *Disclosure of Written Communications Between Vincent Rue and Defendants' Experts (redacted)* filed by Plaintiff Lamar Robinson, M.D., Plaintiff Nova Health Systems, Plaintiff Killeen Woman's Health Center, Plaintiff Sherwood C. Lynn, Jr., M.D., Plaintiff Lendol L. Davis, M.D., Plaintiff Whole Woman's Health, Plaintiff Austin Woman's Health Center, Plaintiff Abortion Advantage, Plaintiff Pamela J. Richter, D.O. (Toti, Stephanie) Modified on 7/31/2014 to modify text (klw). (Entered: 07/31/2014)
07/31/2014	138	Minute Entry for proceedings held before Judge Andrew W. Austin: Motion Hearing held on 7/31/2014 re 115 MOTION to Compel *Disclosure of Written Communications Between Vincent Rue and Defendants' Experts (redacted)* **and** 119 MOTION to Compel *Responses to Interrogatories.* Motions ruled on

		in court. Written Order to follow. (Minute entry documents are not available electronically.) (Court Reporter ERO.)(klw) (Entered: 07/31/2014)
07/31/2014	139	NOTICE—*Plaintiffs' Amended Deposition Designations* by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health (Lawrence, J.) (Entered: 07/31/2014)
07/31/2014	140	Response in Opposition to Motion, filed by David Lakey, MD, Mari Robinson, re 127 MOTION in Limine *to Exclude Evidence Pertaining to the Availability of Abortion Services Outside of the State of Texas* filed by Plaintiff Lamar Robinson, M.D., Plaintiff Nova Health Systems, Plaintiff Killeen Woman's Health Center, Plaintiff Sherwood C. Lynn, Jr., M.D., Plaintiff Lendol L. Davis, M.D., Plaintiff Whole Woman's Health, Plaintiff Austin Woman's Health Center, Plaintiff Abortion Advantage, Plaintiff Pamela J. Richter, D.O. 135 MOTION in Limine *to Exclude Irrelevant Testimony* filed by Plaintiff Nova Health Systems, Plaintiff Killeen Woman's

		Health Center, Plaintiff Sherwood C. Lynn, Jr., M.D., Plaintiff Lendol L. Davis, M.D., Plaintiff Austin Woman's Health Center, Plaintiff Whole Woman's Health, Plaintiff Pamela J. Richter, D.O. (Attachments: # 1 Proposed Order Proposed Order Denying Plaintiffs' Motions in Limine)(Soto, Esteban) (Entered: 07/31/2014)
07/31/2014	141	**AMENDED** Exhibit List *State Defendants' Exhibit List* by David Lakey, MD, Mari Robinson.. (Soto, Esteban) Modified on 8/1/2014 to modify text (klw). (Entered: 07/31/2014)
07/31/2014	142	ORDER GRANTING IN PART AND DENYING IN PART Plaintiff's 115 Motion to Compel Disclosure of Written Communications between Vincent Rue and Defendants' Experts. Signed by Judge Andrew W. Austin. (klw) (Entered: 08/01/2014)
07/31/2014	143	ORDER GRANTING IN PART AND DENYING IN PART Plaintiffs' 119 Motion to Compel Responses to Interrogatories. Signed by Judge Andrew W. Austin. (klw: (Entered: 08/01/2014)
07/31/2014		Motions No Longer Referred: 119 MOTION to Compel *Responses to Interrogatories* and 115 MOTION

		to Compel *Disclosure of Written Communications Between Vincent Rue and Defendants' Experts (redacted).* (klw) (Entered: 08/01/2014)
08/01/2014	144	Minute Entry for proceedings held before Judge Lee Yeakel: Final Pretrial Conference held on 8/1/2014. Court ORALLY Denies 127 Motion in Limine and ORALLY Denies 135 Motion in Limine. Trial details finalized. (Minute entry documents are not available electronically.). (Court Reporter Arlinda Rodriguez.)(klw) (Entered: 08/01/2014)
08/01/2014		ORAL ORDER DENYING Plaintiffs' 127 Motion in Limine *and* DENYING Plaintiffs' 135 Motion in Limine during 144 Final Pretrial Conference. Signed by Judge Lee Yeakel. (klw) (Entered: 08/01/2014)
08/01/2014	145	ORDER GRANTING 126 Motion for Melissa A. Cochen to Appear Pro Hoc Vice on behalf of non-parties Planned Parenthood Center for Choice, Planned Parenthood of Greater Texas Surgical Health Services, and Planned Parenthood South Texas Surgical Center and the Court. Pursuant to our Administrative Policies and Procedures for Electronic Filing, the attorney hereby granted to practice pro hac

		vice in this case must register for electronic filing with our court within 10 days of this order. Signed by Judge Lee Yeakel. (klw) (Entered: 08/01/2014)
08/01/2014	146	EMERGENCY Motion for Reconsideration of Magistrate Judge's 142 Order on Motion to Compel by David Lakey, MD, Mari Robinson. (Attachments: # 1 Proposed Order)(Mitchell, Jonathan) Modified on 8/1/2014 to correct event type and text (klw). (Entered: 08/01/2014)
08/01/2014		Notice of Correction: re 146 Objection. **Clerk modified the entry as it was incorrectly filed as an Objection instead of as a Motion. Motion event created.** (klw) (Entered: 08/01/2014)
08/01/2014	147	ORDER DENYING State Defendants' 146 Emergency Motion Objecting to Magistrate's 142 Order on Motion to Compel. Signed by Judge Lee Yeakel. (klw) (Entered: 08/01/2014)
08/01/2014	148	ORDER GRANTING in Part, DENYING in Part State Defendants' 48 Motion to Dismiss to the following extent: (1) Plaintiffs' challenges to the admitting privileges requirement and the ambulatory-surgical-center requirement

		under the Equal Protection Clause of the Fourteenth Amendment are DISMISSED; (2) Plaintiffs' improper delegation of lawmaking authority claims are DISMISSED; (3) Plaintiffs' claims that both requirements constitute arbitrary and unreasonable state action are DISMISSED. In all other respects, the State's motion is DENIED. Signed by Judge Lee Yeakel. (klw) (Entered: 08/01/2014)
08/02/2014	149	MOTION for Protective Order *to Withhold Privileged Documents* by David Lakey, MD, Mari Robinson. (Attachments: # 1 Proposed Order Proposed Order)(Soto, Esteban) (Entered: 08/02/2014)
08/03/2014	150	Opposed MOTION *to Clark the Scope of Trial* re 148 Order on Motion to Dismiss for Failure to State a Claim,, by David Lakey, MD, Mari Robinson. (Attachments: # 1 Proposed Order Proposed Order Granting Motion)(Soto, Esteban) (Entered: 08/03/2014)
08/03/2014	151	Response in Opposition to Motion, filed by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health, re 149 MOTION for Protective Order *to*

		Withhold Privileged Documents filed by Defendant Mari Robinson, Defendant David Lakey, M.D. (Toti, Stephanie) (Entered: 08/03/2014)
08/04/2014	152	NOTICE *State Defendants' Assertion of Affirmative Defenses* by David Lakey, MD, Mari Robinson re 1 Complaint, (Soto, Esteban) (Entered: 08/04/2014)
08/04/2014	153	MOTION to Exclude *Expert Testimony of Daniel Grossman, M.D.* by David Lakey, MD, Mari Robinson. (Attachments: # 1 Exhibit, # 2 Proposed Order)(Klusmann, Beth) (Entered: 08/04/2014)
08/04/2014	154	STIPULATION *; Joint Stipulation to Facts* by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health. (Toti, Stephanie) (Entered: 08/04/2014)
08/04/2014	156	ORDER GRANTING IN PART AND DENYING IN PART State Defendants' 149 Motion for Protective Order to Withhold Privileged Documents. Signed by Judge Andrew W. Austin. (klw) (Entered: 08/04/2014)
08/04/2014	157	AGREED List of Trial Exhibits.(klw) (Entered: 08/04/2014)

08/04/2014	158	Minute Entry for proceedings held before Judge Lee Yeakel: Bench Trial begun and held on 8/4/2014. Opening statements heard. Testimony and evidence presented by Plaintiff. Court Orally DENIES Defendants' 150 Motion to Clarify the Scope of the Trial. Court Orally DENIES Defendants' 153 Motion to Exclude Expert Testimony of Dr. Grossman. Recessed to 08/05/14 at 9:00 a.m. (Minute entry documents are not available electronically.) (Court Reporter Arlinda Rodriguez.)(klw) (Entered: 08/04/2014)
08/04/2014		ORAL ORDER DENYING Defendants' 150 Motion to Clarify the Scope of the Trial announced in 158 Bench Trial. Signed by Judge Lee Yeakel. (klw) (Entered: 08/04/2014)
08/04/2014		ORAL ORDER DENYING Defendants' 153 Motion to Exclude Expert Testimony of Dr. Grossman announced in 158 Bench Trial. Signed by Judge Lee Yeakel. (klw) (Entered: 08/04/2014)
08/04/2014	159	Response in Opposition to Motion, filed by David Lakey, MD, Mari Robinson, re 123 MOTION to Exclude *Rebuttal Testimony by Mayra Thompson* filed by Plaintiff Lendol L. Davis, M.D., Plaintiff Nova Health Systems, Plaintiff

Killeen Woman's Health Center, Plaintiff Austin Woman's Health Center, Plaintiff Whole Woman's Health, Plaintiff Pamela J. Richter, D.O., Plaintiff Sherwood C. Lynn, Jr., M.D. (Attachments: # 1 Exhibit, # 2 Exhibit, # 3 Proposed Order)(Klusmann, Beth) (Entered: 08/04/2014)

08/04/2014 160 NOTICE *; Direct Testimony of Anne Layne-Farrar, Ph.D.* by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health (Toti, Stephanie) (Entered: 08/04/2014)

08/04/2014 161 NOTICE *; Direct Testimony of Daniel Grossman, M.D.* by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health (Toti, Stephanie) (Entered: 08/04/2014)

08/04/2014 162 NOTICE *; Direct Testimony of Elizabeth Gray Raymond, M.D., M.P.H.* by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter,

DO, Whole Woman's Health (Toti, Stephanie) (Entered: 08/04/2014)

08/04/2014 163 NOTICE *; Direct Testimony of George W. Johannes, AIA* by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health (Toti, Stephanie) (Entered: 08/04/2014)

08/04/2014 164 NOTICE *; Direct Testimony of Kristine Hopkins, Ph.D.* by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health (Toti, Stephanie) (Entered: 08/04/2014)

08/04/2014 165 NOTICE *; Direct Testimony of Lendol L. ("Tad") Davis, M.D.* by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health (Toti, Stephanie) (Entered: 08/04/2014)

08/04/2014 166 NOTICE *; Direct Testimony of Lucila ("Lucy") Ceballos Felix* by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen

		Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health (Toti, Stephanie) (Entered: 08/04/2014)
08/04/2014	167	NOTICE *; Direct Testimony of Paul M. Fine, M.D.* by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health (Toti, Stephanie) (Entered: 08/04/2014)
08/04/2014	168	NOTICE *; Direct Testimony of Sherwood C. Lynn, Jr., M.D.* by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health (Toti, Stephanie) (Entered: 08/04/2014)
08/04/2014	169	NOTICE *Amended Table 4 to Direct Testimony of Kristine Hopkins, Ph.D.* by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health re 164 Notice (Other), (Toti, Stephanie) (Entered: 08/04/2014)

08/05/2014	170	Minute Entry for proceedings held before Judge Lee Yeakel: Bench Trial Continued on 8/5/2014. Testimony and evidence presented by Plaitiffs. Trial recessed until 08/06/14 at 1:30 p.m. (Minute entry documents are not available electronically.). (Court Reporter Arlinda Rodriguez.)(klw) (Entered: 08/05/2014)
08/05/2014	171	NOTICE *; Direct Testimony of Amy Hagstrom Miller* by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health (Toti, Stephanie) (Entered: 08/05/2014)
08/05/2014	172	NOTICE *; Direct Testimony of Marilyn Eldridge* by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health (Toti, Stephanie) (Entered: 08/05/2014)
08/06/2014	173	MOTION for Protective Order *State Defendants' Motion to Withhold Privileged Document* by David Lakey, MD, Mari Robinson. (Attachments: # 1 Proposed Order Proposed Order Granting State

Defendants' Motion)(Soto, Esteban) (Entered: 08/06/2014)

08/06/2014 174 Response in Opposition to Motion, filed by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health, re 173 MOTION for Protective Order *State Defendants' Motion to Withhold Privileged Document* filed by Defendant Mari Robinson, Defendant David Lakey, M.D. (Attachments: # 1 Exhibit A)(Toti, Stephanie) (Entered: 08/06/2014)

08/06/2014 175 Minute Entry for proceedings held before Judge Lee Yeakel: Bench Trial Continued on 8/6/2014. Testimony &Evidence presented on behalf of Defendant. Plaintiff to continue with testimony &evidence on 08/07/14. Defts offer binder of **Expert Witness Direct Testimony of Mayra Thompson, M.D., James Anderson, M.D. and Todd Giberson**—Court ordered the testimony be made part of the record. (Minute entry documents are not available electronically.). (Court Reporter Arlinda Rodriguez.)(klw) (Additional attachment(s) added on 8/7/2014: # 1 Direct Testimony of Mayra Jimenez

Thompson, M.D., # 2 Direct Testimony of James Anderson, M.D., # 3 Direct Testimony of Todd Giberson) (klw). (Entered: 08/07/2014)

08/07/2014 176 NOTICE *; Plaintiffs' Counter-Designations and Objections* by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health (Toti, Stephanie) (Entered: 08/07/2014)

08/07/2014 177 RESPONSE *Defendants' Counter Designations* by David Lakey, MD, Mari Robinson. (Stephens, Andrew) Modified on 8/11/2014 to correct filing parties (klw). (Entered: 08/07/2014)

08/07/2014 178 Minute Entry for proceedings held before Judge Lee Yeakel: Bench Trial Continued on 8/7/2014. Testimony and evidence presented for both Plaintiffs and Defendants. Court **SEALS** Plaintiffs' Exhibits P-25, P-26, P-27 and P-206 (a CD). Deposition excerpts due 08/11/14. Post submission briefs due 08/12/14 by 5p.m. Court Orally DISMISSED Motions 120, 123, 128 and 173 . Defts offer binder of **Expert Witness Direct Testimony of Deborah Kitz, Ph.D., Peter Uhlenberg, Ph.D. and**

		Nagla Elerian—Court ordered the testimony to be made part of the record. Bench trial recessed until 08/13/14 at 10:00 a.m. for Closing Arguments. (Minute entry documents are not available electronically.). (Court Reporter Arlinda Rodriguez.) (Attachments: # 1 Direct Testimony of Deborah Kitz, Ph.D., # 2 Direct Testimony of Peter Uhlenberg, Ph.D., # 3 Direct Testimony of Nagla Elerian)(klw) (Entered: 08/08/2014)
08/07/2014		ORAL ORDER DISMISSING Defendants' 120 Motion to exclude Expert Testimony; DISMISSING Plaintiffs' 123 Motion to exclude Rebuttal Testimony; DISMISSING Plaintiffs' 128 Motion for Leave to File Sealed Document; DISMISSING Defendants' 173 Motion for Protective Order issued during 178 Bench Trial proceedings by Judge Lee Yeakel. (klw) (Entered: 08/08/2014)
08/07/2014	179	LIST OF TRIAL WITNESSES from 158, 170, 175 and 178 Bench Trial.(klw) (Entered: 08/08/2014)
08/07/2014	180	Defendants' Trail Exhibit List as to David Lakey, MD and Mari Robinson for 158, 170, 175 and 178 Bench Trial.(klw) (Entered: 08/11/2014)

08/11/2014	181	NOTICE *State Defendants' Objections and Amended Counter-Deposition Designations* by David Lakey, MD, Mari Robinson re 139 Notice (Other), (Soto, Esteban) (Entered: 08/11/2014)
08/12/2014	182	Exhibit List *; Plaintiffs' Final Trial Exhibit List* by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health.. (Toti, Stephanie) (Entered: 08/12/2014)
08/12/2014	183	Plaintiffs' Trial Exhibit List for 158, 170, 175 and 178 Bench Trial.(klw) (Entered: 08/12/2014)
08/12/2014	184	TRIAL BRIEF by David Lakey, MD, Mari Robinson. (Mitchell, Jonathan) (Entered: 08/12/2014)
08/12/2014	185	TRIAL BRIEF by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health. (Toti, Stephanie) (Entered: 08/12/2014)
08/13/2014	186	Minute Entry for proceedings held before Judge Lee Yeakel: Bench Trial concluded on 8/13/2014. Pltf orally moves to withdraw exhibits

P197, P-198, P-199, P-200 and P-201 which were offered in error—Orally granted. Plft confirms Sealed Exhibit P-206 is in transit. Closing arguments made on both sides. Case under submission and all matters under advisement. Written Opinion forthcoming. (Minute entry documents are not available electronically.) (Court Reporter Arlinda Rodriguez.)(klw) (Entered: 08/13/2014)

08/14/2014 187 NOTICE *; Plaintiffs' Notice Regarding State Defendants' Failure to Comply With Order* by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health re 142 Order on Motion to Compel (Toti, Stephanie) (Additional attachment(s) added on 8/15/2014: # 1 SEALED Unredacted Exhibit B) (klw). (Entered: 08/14/2014)

08/14/2014 188 Motion for leave to File Sealed Document (Attachments: # 1 Sealed Document) (Toti, Stephanie) (Entered: 08/14/2014)

08/15/2014 189 ORDER GRANTING Plaintiffs' 188 Motion for Leave to File Sealed Exhibit B to Plaintiffs' Notice Regarding State Defendants'

		Failure to Comply with Order. Signed by Judge Lee Yeakel. (klw) (Entered: 08/15/2014)
08/15/2014	190	ANSWER to 1 Complaint, by David Lakey, MD, Mari Robinson.(Stephens, Andrew) (Entered: 08/15/2014)
08/15/2014	191	RESPONSE to 187 Notice (Other), by David Lakey, MD, Mari Robinson. (Stephens, Andrew) (Entered: 08/15/2014)
08/21/2014	192	Transcript filed of Proceedings held on August 4, 2014, Proceedings Transcribed: Bench Trial Volume 1. Court Reporter/Transcriber: Arlinda Rodriguez, Telephone number: 512-391-8791. Parties are notified of their duty to review the transcript to ensure compliance with the FRCP 5.2(a)/FRCrP 49.1(a). A copy may be purchased from the court reporter or viewed at the clerk's office public terminal. If redaction is necessary, a Notice of Redaction Request must be filed within 21 days. If no such Notice is filed, the transcript will be made available via PACER without redaction after 90 calendar days. The clerk will mail a copy of this notice to parties not electronically noticed Redaction Request due 9/11/2014, Redacted Transcript Deadline set for 9/22/2014, Release

of Transcript Restriction set for 11/19/2014, (Rodriguez, Arlinda) Modified on 8/21/2014 to correct trial type (klw). (Entered: 08/21/2014)

08/21/2014 193 Transcript filed of Proceedings held on August 5, 2014, Proceedings Transcribed: Bench Trial Volume 2. Court Reporter/Transcriber: Arlinda Rodriguez, Telephone number: 512-391-8791. Parties are notified of their duty to review the transcript to ensure compliance with the FRCP 5.2(a)/FRCrP 49.1(a). A copy may be purchased from the court reporter or viewed at the clerk's office public terminal. If redaction is necessary, a Notice of Redaction Request must be filed within 21 days. If no such Notice is filed, the transcript will be made available via PACER without redaction after 90 calendar days. The clerk will mail a copy of this notice to parties not electronically noticed Redaction Request due 9/11/2014, Redacted Transcript Deadline set for 9/22/2014, Release of Transcript Restriction set for 11/19/2014, (Rodriguez, Arlinda) Modified on 8/21/2014 to correct jury type (klw). (Entered: 08/21/2014)

08/21/2014 194 Transcript filed of Proceedings held on August 7, 2014, Proceedings

		Transcribed: Bench Trial Volume 4. Court Reporter/Transcriber: Arlinda Rodriguez, Telephone number: 512-391-8791. Parties are notified of their duty to review the transcript to ensure compliance with the FRCP 5.2(a)/FRCrP 49.1(a). A copy may be purchased from the court reporter or viewed at the clerk's office public terminal. If redaction is necessary, a Notice of Redaction Request must be filed within 21 days. If no such Notice is filed, the transcript will be made available via PACER without redaction after 90 calendar days. The clerk will mail a copy of this notice to parties not electronically noticed Redaction Request due 9/11/2014, Redacted Transcript Deadline set for 9/22/2014, Release of Transcript Restriction set for 11/19/2014, (Rodriguez, Arlinda) Modified on 8/21/2014 to correct trial type (klw). (Entered: 08/21/2014)
08/21/2014	195	Transcript filed of Proceedings held on August 6, 2014, Proceedings Transcribed: Bench Trial Volume 3. Court Reporter/Transcriber: Arlinda Rodriguez, Telephone number: 512-391-8791. Parties are notified of their duty to review the transcript to ensure compliance with the FRCP 5.2(a)/FRCrP

49.1(a). A copy may be purchased from the court reporter or viewed at the clerk's office public terminal. If redaction is necessary, a Notice of Redaction Request must be filed within 21 days. If no such Notice is filed, the transcript will be made available via PACER without redaction after 90 calendar days. The clerk will mail a copy of this notice to parties not electronically noticed Redaction Request due 9/11/2014, Redacted Transcript Deadline set for 9/22/2014, Release of Transcript Restriction set for 11/19/2014, (Rodriguez, Arlinda) Modified on 8/21/2014 to correct trial type (klw). (Entered: 08/21/2014)

08/21/2014 196 OPINION ORDER re: 142 Order Granting in Part and Denying in Part Plaintiff's 115 MOTION to Compel *Disclosure of Written Communications Between Vincent Rue and Defendants' Experts* **and** 156 Order Granting in Part and Denying in Part State Defendants' 149 Motion for Protective Order to Withhold Privileged Documents. Signed by Judge Andrew W. Austin. (klw) (Entered: 08/21/2014)

08/29/2014 197 Transcript filed of Proceedings held on August 13, 2014, Proceedings Transcribed: Bench Trial Volume 5

(Closing Arguments). Court Reporter/Transcriber: Arlinda Rodriguez, Telephone number: 512-391-8791. Parties are notified of their duty to review the transcript to ensure compliance with the FRCP 5.2(a)/FRCrP 49.1(a). A copy may be purchased from the court reporter or viewed at the clerk's office public terminal. If redaction is necessary, a Notice of Redaction Request must be filed within 21 days. If no such Notice is filed, the transcript will be made available via PACER without redaction after 90 calendar days. The clerk will mail a copy of this notice to parties not electronically noticed Redaction Request due 9/19/2014, Redacted Transcript Deadline set for 9/29/2014, Release of Transcript Restriction set for 11/28/2014, (Rodriguez, Arlinda) (Entered: 08/29/2014)

08/29/2014	198	MEMORANDUM OPINION AND ORDER Incorporating Finding of Facts and Conclusions of Law. Signed by Judge Lee Yeakel. (klw) (Entered: 08/29/2014)
08/29/2014	199	FINAL JUDGMENT. Signed by Judge Lee Yeakel. (klw) (Entered: 08/29/2014)
08/29/2014	200	Appeal of Final Judgment 199 by David Lakey, MD, Mari Robinson.

		(Filing fee $ 505 receipt number 0542-6782871) (Mitchell, Jonathan) (Entered: 08/29/2014)
08/29/2014		NOTICE OF APPEAL following 200 Notice of Appeal (E-Filed) by David Lakey, MD, Mari Robinson. Filing fee $ 505, receipt number 0542-6782871. Per 5th Circuit rules, the appellant has 14 days, from the filing of the Notice of Appeal, to order the transcript. To order a transcript, the appellant should fill out Form DKT-13 (Transcript Order) and follow the instructions set out on the form. This form is available in the Clerk's Office or by clicking the hyperlink above. (klw) (Entered: 09/02/2014)
08/31/2014	201	MOTION for Leave to Exceed Page Limitation by David Lakey, MD, Mari Robinson. (Attachments: # 1 Appendix Stay Motion, # 2 Proposed Order)(Mitchell, Jonathan) (Entered: 08/31/2014)
08/31/2014	202	MOTION to Stay *Judgment* by David Lakey, MD, Mari Robinson. (Attachments: # 1 Proposed Order)(Mitchell, Jonathan) (Entered: 08/31/2014)
09/02/2014	203	ORDER GRANTING Defendant's 201 Motion for Leave to File Excess Pages in filing of their Motion to

		Stay Judgment. Signed by Judge Lee Yeakel. (klw) (Entered: 09/02/2014)
09/03/2014	204	ORDER of USCA GRANTING Appellants' Motion for Leave to file their Motion for Stay pending Appeal; Response due by 09/08/14 at 5:00 p.m.; Reply due by 09/10/14 at 5:00 p.m. ORAL ARGUMENTS set for 09/12/14 at 10:00 a.m. in New Orleans.(klw) (Entered: 09/03/2014)
09/03/2014		NOTICE of Certification of the Electronic Record on Appeal accepted by the USCA Fifth Circuit as to 200 Notice of Appeal (E-Filed). (klw) (Entered: 09/03/2014)
09/03/2014	205	Transmitted Record on Appeal to USCA Fifth Circuit re Notice of Appeal. Record consists of 3 Binders of Plaintiffs' Bench Trial Exhibits; 1 Binder of Defendants' Bench Trial Exhibits; 1 Envelope of Plaintiffs' SEALED Bench Trial Exhibits (P2 5, P26, P27 &P206). (klw) (Entered: 09/03/2014)
09/03/2014	206	Response in Opposition to Motion, filed by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health, re 202

		MOTION to Stay *Judgment* filed by Defendant Mari Robinson, Defendant David Lakey, M.D. (Toti, Stephanie) (Entered: 09/03/2014)
09/03/2014	207	TRANSCRIPT REQUEST by David Lakey, MD, Mari Robinson. No transcripts necessary—already on file. (klw) (Entered: 09/04/2014)
09/08/2014	208	ORDER DENYING State Defendants' 202 Motion to Stay Final Judgment pending Appeal. Signed by Judge Lee Yeakel. (klw) (Entered: 09/09/2014)
09/09/2014		NOTICE of Certification of the First Supplemental Electronic Record on Appeal accepted by the USCA re: 200 Notice of Appeal (E-Filed). (klw) (Entered: 09/09/2014)
09/09/2014	209	Unopposed MOTION for Extension of Time to File *Fee Application* by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health. (Toti, Stephanie) (Entered: 09/09/2014)
09/10/2014	210	ORDER GRANTING Plaintiffs' 209 Motion for Extension of Time to File Application Fee until thirty (30) days after the exhaustion of all appeals in this matter including review or requests for review by

		the United States Supreme Court. Signed by Judge Lee Yeakel. (klw) (Entered: 09/10/2014)
09/10/2014	211	Cross Appeal of Final Judgment 199 by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health. (Filing fee $ 505 receipt number 0542-6812067) (Toti, Stephanie) (Entered: 09/10/2014)
09/10/2014		NOTICE OF CROSS-APPEAL following 211 Notice of Appeal (E-Filed), by Austin Woman's Health Center, Lendol L. Davis, MD, Killeen Woman's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health. Filing fee $ 505, receipt number 0542-6812067. Per 5th Circuit rules, the appellant has 14 days, from the filing of the Notice of Appeal, to order the transcript. To order a transcript, the appellant should fill out Form DKT-13 (Transcript Order) and follow the instructions set out on the form. This form is available in the Clerk's Office or by clicking the hyperlink above. (klw) (Entered: 09/11/2014)

09/11/2014	212	ORDER of USCA regarding motion for stay pending appeal. (kkc) (Entered: 09/11/2014)
09/12/2014		NOTICE of Certification of the Second Supplemental Electronic Record on Appeal accepted by the USCA re: 200 Notice of Appeal (E-Filed). (klw) (Entered: 09/15/2014)
09/19/2014	213	Acknowledgement Receipt for Record on Appeal by USCA Fifth Circuit re 205 Appeal Record Transmitted consisting of 3 Binders of Plaintiffs' Bench Trial Exhibits; 1 Binder of Defendants' Bench Trial Exhibits; 1 Envelope of Plaintiffs' SEALED Bench Trial Exhibits (P2 5, P26, P27 &P206).(klw) (Entered: 09/19/2014)
10/06/2014	214	ORDER of USCA (certified copy) re Notice of Appeal and Cross Notice of Appeal. (klw) (Entered: 10/06/2014)
10/17/2014	215	ORDER of USCA (certified copy) that Appellants' motion for expedited consideration, which is joined by Appellees, is GRANTED. (klw) (Entered: 10/17/2014)
10/23/2014	216	ORDER of USCA (certified copy) that the joint motion to view sealed pages 3474-4312 and bench trial exhibits of the record on appeal is GRANTED as to Notice of Appeal

		and Cross Notice of Appeal. (klw) (Entered: 10/23/2014)
10/29/2014	217	Unopposed MOTION *to Include Deposition Excerpts in the Record* by David Lakey, MD, Mari Robinson. (Attachments: # 1 Proposed Order)(Klusmann, Beth) (Entered: 10/29/2014)
10/30/2014	218	ORDER GRANTING Plaintiffs' 217 Motion to Include Deposition Excepts in the record Signed by Judge Lee Yeakel. (klw) ***(Clerk notes 1 binder placed on shelf in the clerk's office.)*** (Entered: 10/30/2014)
10/30/2014	219	Transmitted First Supplemental Record on Appeal to USCA Fifth Circuit re Notice of Appeal and Notice of Cross Appeal consisting of 1 Binder of Plaintiffs' &Defendants' Deposition Designations. (klw) (Entered: 10/30/2014)
01/15/2015	220	NOTICE of Substitution of Counsel *Jonathan F. Mitchell* by David Lakey, MD, Mari Robinson. (Keller, Scott) Modified on 1/15/2015 to correct event (kkc). (Entered: 01/15/2015)
01/15/2015		Notice of Correction: re 220 MOTION to Substitute Attorney *Jonathan F. Mitchell*. Notice of Substitution of Counsel. Attorneys may not be substituted using this

notification. A motion for substitution of counsel is required. Scott A. Keller is reflected on the docket as additional counsel of record, but does not terminate existing co-counsel. (kkc) (Entered: 01/15/2015)

01/15/2015 221 MOTION to Substitute Attorney *Jonathan F. Mitchell* by David Lakey, MD, Mari Robinson. (Attachments: # 1 Proposed Order)(Keller, Scott) (Entered: 01/15/2015)

01/16/2015 222 ** **WITHDRAWN pursuant to 228 Order** ** MOTION *to Intervene in this Matter to Obtain the Right to Use Documents Designated Under the Amended Confidentiality and Protective Order* by June Medical Services LLC d/b/a Hope Medical Group for Women, Bossier City Medical Suite, Choice Inc., of Texas d/b/a Causeway Medical Clinic, John Doe 1, M.D., John Doe 2, M.D.. (Toti, Stephanie) Modified on 2/19/2015 (klw). (Entered: 01/16/2015)

01/20/2015 223 ORDER GRANTING Lakey and Robinson's 221 Motion to Substitute Attorney Scott A. Keller in place of Jonathan F. Mitchell. Signed by Judge Lee Yeakel. (klw) (Entered: 01/20/2015)

01/23/2015	224	RESPONSE to Motion, filed by David Lakey, MD, Mari Robinson, re 222 MOTION *to Intervene in this Matter to Obtain the Right to Use Documents Designated Under the Amended Confidentiality and Protective Order* filed by Movant Choice Inc., of Texas, Movant John Doe 1, M.D., Movant Bossier City Medical Suite, Movant John Doe 2, M.D., Movant June Medical Services LLC (Attachments: # 1 Proposed Order)(Klusmann, Beth) (Entered: 01/23/2015)
01/25/2015	225	REPLY to Response to Motion, filed by Bossier City Medical Suite, Choice Inc., of Texas, John Doe 1, M.D., John Doe 2, M.D., June Medical Services LLC, re 222 MOTION *to Intervene in this Matter to Obtain the Right to Use Documents Designated Under the Amended Confidentiality and Protective Order* filed by Movant Choice Inc., of Texas, Movant John Doe 1, M.D., Movant Bossier City Medical Suite, Movant John Doe 2, M.D., Movant June Medical Services LLC (Toti, Stephanie) (Entered: 01/25/2015)
02/17/2015	226	MOTION to Withdraw as Attorney—*Motion to Withdraw Marissa P. Harris, Colin M OBrien, Esha Bhandari, and Natasha Lycia Ora*

Bannan as Counsel for Plaintiffs by Austin Women's Health Center, Lendol L. Davis, MD, Killeen Women's Health Center, Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health. (Attachments: # 1 Proposed Order)(Toti, Stephanie) (Entered: 02/17/2015)

02/19/2015 227 NOTICE *of Withdrawal of the Motion to Intervene* by Bossier City Medical Suite, John Doe 1, M.D., John Doe 2, M.D., June Medical Services LLC re 222 MOTION *to Intervene in this Matter to Obtain the Right to Use Documents Designated Under the Amended Confidentiality and Protective Order* (Toti, Stephanie) (Entered: 02/19/2015)

02/19/2015 228 ORDER **WITHDRAWING** 222 MOTION *to Intervene in this Matter to Obtain the Right to Use Documents Designated Under the Amended Confidentiality and Protective Order pursuant to 227 Notice to Withdraw filed by John Doe 1, M.D., Bossier City Medical Suite, John Doe 2, M.D., June Medical Services LLC*, filed by Choice Inc., of Texas, John Doe 1, M.D., Bossier City Medical Suite, John Doe 2, M.D., June Medical

		Services LLC. Signed by Judge Lee Yeakel. (klw) (Entered: 02/19/2015)
02/24/2015	229	ORDER GRANTING 226 Motion for Marissa P. Harris, Cohn M. O'Brien,Esha Bhandari, and Natasha Lycia Ora Barman to Withdraw as Counsel for plaintiff. Signed by Judge Lee Yeakel. (klw) (Entered: 02/24/2015)
06/22/2015	230	ORDER of USCA re Notice of Appeal: ORDER MODIFYING the 06/09/15 Opinion and Judgment to provide that the district courts injunction of the ASC requirement (as defined in the 06/09/15 Opinion) as applied to the McAllen facility shall remain in effect until 10/29/15, at which time the injunction shall be vacated in part, as delineated and explained in our 06/09/15 Opinion. The Opposed Appellees Motion to Stay the Mandate, filed 06/15/15, is DENIED. (klw) (Entered: 06/22/2015)
08/07/2015	231	MOTION *to Clarify the Judgment* by David Lakey, MD, Mari Robinson. (Attachments: # 1 Exhibit, # 2 Proposed Order)(Klusmann, Beth) (Entered: 08/07/2015)
08/14/2015	232	Response in Opposition to Motion, filed by Austin Women's Health Center, Lendol L. Davis, MD, Killeen Women's Health Center,

		Sherwood C. Lynn, Jr., MD, Nova Health Systems, Pamela J. Richter, DO, Whole Woman's Health, re 231 MOTION *to Clarify the Judgment* filed by Defendant Mari Robinson, Defendant David Lakey, M.D. (Toti, Stephanie) (Entered: 08/14/2015)
08/17/2015	233	REPLY to Response to Motion, filed by David Lakey, MD, Mari Robinson, re 231 MOTION *to Clarify the Judgment* filed by Defendant Mari Robinson, Defendant David Lakey, M.D. (Klusmann, Beth) (Entered: 08/17/2015)
08/17/2015	234	ORDER DENYING Defendants' 231 Motion to clarify the judgment. The Court further ORDERS Defendants to immediately cease and desist from enforcing the ASC requirement, Tex. Health &Safety Code Ann. § 245.0 10(a), against Plaintiff Nova Health Systems d/b/a Reproductive Services. Failure to comply with this Order shall subject Defendants to sanctions for contempt of court. Signed by Judge Lee Yeakel. (klw) (Entered: 08/17/2015)
11/19/2015	235	WRIT OF CERTIORARI re Notice of Appeal GRANTED by US Supreme Court. (klw) (Entered: 11/20/2015)

General Docket
United States Court of Appeals
for the Fifth Circuit

Court of Appeals **Docketed:** 08/30/2014
Docket #: 14-50928 **Termed:** 06/09/2015
Nature of Suit: 3440
Other Civil Rights
Whole Woman's Health, et
al v. David Lakey, et al
Appeal From: Western
District of Texas, Austin
Fee Status: Fee Paid

08/30/2014	CIVIL RIGHTS CASE docketed. NOA filed by Appellants David Lakey, M.D. and Ms. Mari Robinson [1450928] (JMW)
08/30/2014	CASE CAPTION updated. Involvement terminated for Appellees Abortion Advantage and Lamar Robinson in 14-50928. Reason: not party to appeal. [14-50928] (JMW)
08/30/2014	Attorney Stephanie Toti & J. Alexander Lawrence added as counsel of record for Appellees Whole Woman's Health, Austin Woman's Health Center, Killeen Woman's Health Center, Nova Health Systems, Sherwood C. Lynn Jr., Pamela J. Richter and Lendol I> Davis in 14-50928 [14-50928] (JMW)
08/31/2014	OPPOSED MOTION filed by Appellants David Lakey, M.D. and Ms. Mari Robinson for stay pending appeal [7718648-2] Ruling is requested by: 09/02/2014 at

	12:00 am. Date of service: 08/31/2014 via email—Attorney for Appellants: Klusmann, Mitchell; Attorney for Appellees: Lawrence, Toti; US mail—Attorney for Appellee: Gizaw [14-50928] REVIEWED AND/OR EDITED. OPPOSED MOTION to expedite the appeal [7718648-3]. Date of service: 08/31/2014 [14-50928] (Jonathan F. Mitchell)
09/01/2014	OPPOSED MOTION filed by Appellants David Lakey, M.D. and Ms. Mari Robinson to file in excess pages the motion for stay pending appeal [7718648-2]. Date of service: 09/01/2014 via email—Attorney for Appellants: Klusmann, Mitchell; Attorney for Appellees: Lawrence, Toti; US mail—Attorney for Appellee: Gizaw [14-50928] (Jonathan F. Mitchell)
09/01/2014	Documents entitled, "Appendix", filed as EXHIBITS IN SUPPORT of motion for stay pending appeal [7718648-2], motion to expedite appeal [7718648-3] filed by Appellants David Lakey, M.D. and Ms. Mari Robinson Date of Service: 08/31/2014 [14-50928] (JMW)
09/02/2014	INITIAL CASE CHECK by Attorney Advisor complete, Action: Case OK to Process. [7718872-2] Initial AA Check Due satisfied.. Transcript order due on 09/17/2014 for Appellants David Lakey and Mari Robinson [14-50928] (PAC)
09/02/2014	COURT ORDER: IT IS ORDERED that appellants' motion for leave to file, in

excess of the page limit, their motion for stay pending appeal is GRANTED. The appellees must file their opposition to the motion by Monday September 8 at 5:00 p.m., which may be up to 33 pages, exclusive of the disclosure statement, the proof of service, and the accompanying documents required by Rule 5(b)(1)(E). The appellants must file their reply in support of the motion by Wednesday September 10 at 5:00 p.m. The attorneys should assume that no extensions will be granted. The court will hear oral arguments on the motion for stay pending appeal at 10:00 a.m. on Friday September 12, 2014, in New Orleans. Each side is permitted 30 minutes of argument. The attorneys are reminded that neither the briefs nor the arguments should refer to anything outside the district court record in this case. The court holds in abeyance the motion to expedite the appeal. (IN DETAIL) [7718649-2]; [7718648-3]; [7718648-2][7718648-3][7719781-2] Response/Opposition deadline updated to 09/08/2014 at 5:00 p.m. ; Reply deadline to response updated to 09/10/2014 at 5:00 p.m. [14-50928] (PAC)

09/03/2014 CASE CALENDARED for oral argument on Friday, 09/12/2014, at 10:00 am in the West Courtroom, Room 265, of the John Minor Wisdom United States Court of Appeals Building, 600 Camp Street, New Orleans, LA. [14-50928] (GAM)

09/03/2014	ELECTRONIC RECORD ON APPEAL REQUESTED FROM DISTRICT COURT. Electronic ROA due on 09/05/2014. [14-50928] (PAC)
09/03/2014	ATTORNEY TRANSCRIPT ORDER form filed by Appellants Mr. David Lakey and Ms. Mari Robinson for the Court to process. Date of service: 09/03/2014 via email—Attorney for Appellants: Klusmann, Mitchell; Attorney for Appellees: Gizaw, Lawrence, Toti. [14-50928] (Jonathan F. Mitchell)
09/03/2014	TRANSCRIPT ORDER received from Appellants Mr. David Lakey and Ms. Mari Robinson advising transcript unnecessary as it is already filed. Transcript Order ddl satisfied [14-50928] (PAC)
09/03/2014	ELECTRONIC RECORD ON APPEAL FILED. Exhibits on File in District Court? Yes. Electronic ROA deadline satisfied. [14-50928] (SMH)
09/03/2014	APPEARANCE FORM FILED by Attorney(s) Jonathan F. Mitchell for party(s) Appellant Mari Robinson Appellant David Lakey, in case 14-50928 [14-50928] (RLL)
09/04/2014	Exhibits, 1 Box (Trial Exhibits—3 Binders of Plt's exhibits; 1 Binder of Def's exhibits), FILED; SEALED EXHIBITS, 1 env. (Plt's Sealed Exhibits), FILED [14-50928] (ALL ORIGINAL EXHIBITS—MUST BE RETURNED TO DC) (MVM)

09/08/2014 APPEARANCE FORM FILED by Attorney(s) Jan Soifer for party(s) Appellee Sherwood C. Lynn Jr. Appellee Whole Woman's Health Appellee Lendol L. Davis Appellee Pamela J. Richter Appellee Nova Health Systems Appellee Killeen Woman's Health Center Appellee Austin Woman's Health Center, in case 14-50928 [14-50928] (AJV)

09/08/2014 APPEARANCE FORM FILED by Attorney Stephanie Toti for Appellee Lendol L. Davis in 14-50928, Attorney Stephanie Toti for Appellee Pamela J. Richter in 14-50928, Attorney Stephanie Toti for Appellee Sherwood C. Lynn Jr. in 14-50928, Attorney Stephanie Toti for Appellee Nova Health Systems in 14-50928, Attorney Stephanie Toti for Appellee Killeen Woman's Health Center in 14-50928, Attorney Stephanie Toti for Appellee Austin Woman's Health Center in 14-50928, Attorney Stephanie Toti for Appellee Whole Woman's Health in 14-50928 [14-50928] (AJV)

09/08/2014 APPEARANCE FORM FILED by Attorney(s) Esha Bhandari for party(s) Appellee Sherwood C. Lynn Jr. Appellee Whole Woman's Health Appellee Lendol L. Davis Appellee Pamela J. Richter Appellee Nova Health Systems Appellee Killeen Woman's Health Center Appellee Austin Woman's Health Center, in case 14-50928 [14-50928] (AJV)

09/08/2014 APPEARANCE FORM FILED by Attorney Beth Ellen Klusmann for Appellant Mari Robinson in 14-50928, Attorney Beth Ellen Klusmann for Appellant David Lakey in 14-50928 [14-50928] (RLL)

09/08/2014 RESPONSE/OPPOSITION filed by Austin Woman's Health Center, Mr. Lendol L. Davis, Killeen Woman's Health Center, Mr. Sherwood C. Lynn, Jr., Nova Health Systems, Ms. Pamela J. Richter and Whole Woman's Health [7724459-1] to the motion for stay pending appeal filed by Appellants Ms. Mari Robinson and Mr. David Lakey in 14-50928 [7718648-2], motion to expedite appeal filed by Appellants Ms. Mari Robinson and Mr. David Lakey in 14-50928 [7718648-3] Date of Service: 09/08/2014 via email—Attorney for Appellants: Klusmann, Mitchell; Attorney for Appellees: Bhandari, Gizaw, Lawrence, Soifer, Toti. [1450928] (Stephanie Toti)

09/09/2014 SUPPLEMENTAL ELECTRONIC RECORD ON APPEAL FILED. [14-50928] (MRB)

09/09/2014 APPEARANCE FORM FILED by Attorney Joseph Alexander Lawrence for Appellee Lendol L. Davis in 14-50928, Attorney Joseph Alexander Lawrence for Appellee Pamela J. Richter in 14-50928, Attorney Joseph Alexander Lawrence for Appellee Sherwood C. Lynn Jr. in 14-50928, Attorney Joseph Alexander Lawrence for Appellee Nova Health

Systems in 14-50928, Attorney Joseph Alexander Lawrence for Appellee Killeen Woman's Health Center in 14-50928, Attorney Joseph Alexander Lawrence for Appellee Austin Woman's Health Center in 14-50928, Attorney Joseph Alexander Lawrence for Appellee Whole Woman's Health in 14-50928 [14-50928] (AJV)

09/09/2014 APPEARANCE FORM FILED by Attorney(s) Michael P. Murphy for party(s) Appellant Mari Robinson Appellant David Lakey, in case 14-50928 [14-50928] (AJV)

09/10/2014 REPLY filed by Appellants Mr. David Lakey and Ms. Mari Robinson [7726942-1] to the response/opposition filed by Appellees Whole Woman's Health, Ms. Pamela J. Richter, Austin Woman's Health Center, Killeen Woman's Health Center, Nova Health Systems, Mr. Sherwood C. Lynn, Jr. and Mr. Lendol L. Davis in 1450928 [7724459-2], to the motion for stay pending appeal filed by Appellants Ms. Mari Robinson and Mr. David Lakey in 14-50928 17718648-21,to the motion to expedite appeal filed by Appellants Ms. Mari Robinson and Mr. David Lakey in 14-50928 [7718648-3]. Date of Service: 09/10/2014 via email—Attorney for Appellants: Klusmann, Mitchell, Murphy; Attorney for Appellees: Bhandari, Gizaw, Lawrence, Soifer, Toti; US mail—Attorney for Appellee: Gizaw. [14-50928] (Jonathan F. Mitchell)

09/10/2014	APPEARANCE FORM FILED by Attorney(s) Andrew S. Oldham for party(s) Appellant Cross-Appellee Mari Robinson Appellant Cross-Appellee David Lakey, in case 14-50928 [14-50928] (MVM)
09/11/2014	CASE CAPTION updated. Cross appeal filed. [7727135-2] Parties updated: Appellees Cross-Appellants Whole Woman's Health, Austin Woman's Health Center, Killeen Woman's Health Center, Nova Health Systems, Sherwood C. Lynn Jr., Pamela J. Richter and Lendol L. Davis; Appellants Cross-Appellees David Lakey and Mari Robinson in 14-50928. in 14-50928. NOA filed by Appellees Austin Woman's Health Center, Mr. Lendol L. Davis, Killeen Woman's Health Center, Mr. Sherwood C. Lynn, Jr., Nova Health Systems, Ms. Pamela J. Richter and Whole Woman's Health. [7727135-1] [14-50928] (RLL)
09/11/2014	INITIAL CASE CHECK by Attorney Advisor complete, Action: Case OK to Process. [7727161-2] Initial AA Check Due satisfied. [14-50928] (RLL)
09/12/2014	SUPPLEMENTAL ELECTRONIC RECORD ON APPEAL FILED. [14-50928] (MRB)
09/12/2014	ORAL ARGUMENT HEARD before Judges Smith, Elrod, Higginson. Arguing Person Information Updated for: Jonathan F. Mitchell arguing for Appellant Cross-Appellee David Lakey and Mari Robinson; Arguing Person Information Updated for: Stephanie Toti arguing for

Appellee Cross-Appellant Austin Woman's Health Center, Appellee Cross-Appellant Lendol L. Davis, Appellee Cross-Appellant Killeen Woman's Health Center, Appellee Cross-Appellant Sherwood C. Lynn, Jr., Appellee Cross-Appellant Nova Health Systems, Appellee Cross-Appellant Pamela J. Richter and Whole Woman's Heath. [14-50928] (PFT)

09/12/2014 APPEARANCE FORM FILED by Attorney(s) David Patrick Brown for party(s) Appellee Cross-Appellant Nova Health Systems Appellee Cross-Appellant Pamela J. Richter Appellee Cross-Appellant Austin Woman's Health Center Appellee Cross-Appellant Lendol L. Davis Appellee Cross-Appellant Whole Woman's Health Appellee Cross-Appellant Killeen Woman's Health Center Appellee Cross-Appellant Sherwood C. Lynn Jr., in case 14-50928 [14-50928] (RLL)

10/02/2014 NON DISPOSITIVE PUBLISHED OPINION FILED. Judge: JES, Judge: JWE, Judge: SAH; granting in part and denying in part motion for stay pending appeal filed by Appellants Cross-Appellees Ms. Mari Robinson and Mr. David Lakey [7718648-2][14-50928] (JMA)

10/07/2014 COURT DIRECTIVE ISSUED requesting a response to the motion to expedite appeal filed by Appellants Cross-Appellees Ms. Mari Robinson and Mr. David Lakey in 14-50928 [7718648-3] Response/Opposition due on 10/10/2014. [14-50928] (PAC)

10/07/2014	JOINDER filed by Appellees Cross-Appellants Austin Women's Health Center, Mr. Lendol L. Davis, Killeen Women's Health Center, Mr. Sherwood C. Lynn, Jr., Nova Health Systems, Ms. Pamela J. Richter and Whole Woman's Health to the motion to expedite appeal filed by Appellants Cross-Appellees Ms. Mari Robinson and Mr. David Lakey in 14-50928 17718648-31,to the motion for stay pending appeal filed by Appellants Cross-Appellees Ms. Mari Robinson and Mr. David Lakey in 14-50928 [7718648-2]. Date of Service: 10/07/2014 via email—Attorney for Appellants Cross-Appellees: Klusmann, Mitchell, Murphy, Oldham; Attorney for Appellees Cross-Appellants: Bhandari, Brown, Gizaw, Lawrence, Soifer, Toti [1450928] (Stephanie Toti)
10/08/2014	REVISED PUBLISHED OPINION FILED. [7745111-2] [14-50928] (RMF)
10/10/2014	SEALED DOCUMENTS [14-50928] (JRD)
10/13/2014	COURT ORDER granting motion to expedite appeal filed by Appellants Cross-Appellees Ms. Mari Robinson and Mr. David Lakey] Judge(s): JWE. [14-50928] (PAC)
10/13/2014	BRIEFING NOTICE ISSUED. EXPEDITED CROSS APPEAL SCHEDULE.[7751604-2] A/Pets Brief Due on 11/03/2014 for Appellants Cross-Appellees David Lakey and Mari Robinson.. XA/Pets Brief due on 11/24/2014 for Appellees Cross-Appellants Austin Women's Health Center,

Lendol L. Davis, Killeen Women's Health Center, Sherwood C. Lynn Jr., Nova Health Systems, Pamela J. Richter and Whole Woman's Health.. XE/Res's Brief due on 12/01/2014 for Appellants Cross-Appellees David Lakey and Mari Robinson. XA/Pet's Reply Brief due on 12/08/2014 for Appellees Cross-Appellants Austin Women's Health Center, Lendol L. Davis, Killeen Women's Health Center, Sherwood C. Lynn Jr., Nova Health Systems, Pamela J. Richter and Whole Woman's Health [14-50928] (PAC)

10/15/2014 SUPREME COURT ORDER received. The application to vacate stay of final judgment pending appeal presented to Justice Scalia and by him referred to the court is granted in part and denied in part. [7753546-2]. [7753546-1] [14-50928] (PAC)

10/20/2014 UNOPPOSED MOTION filed by Appellants Cross-Appellees Mr. David Lakey and Ms. Mari Robinson(Joint Motion) to view sealed document.. Date of service: 10/20/2014 via email—Attorney for Appellants Cross-Appellees: Klusmann, Mitchell, Murphy, Oldham; Attorney for Appellees Cross-Appellants: Bhandari, Brown, Lawrence, Soifer, Toti; US mail—Attorney for Appellee Cross-Appellant: Gizaw [14-50928] (Jonathan F. Mitchell)

10/22/2014 COURT ORDER granting joint motion view sealed document filed by Appellants Cross-Appellees Ms. Mari Robinson and Mr. David Lakey [7756001-2] Judge(s): JWE. [14-50928] (MVM)

10/30/2014	CASE TENTATIVELY calendared for oral argument for the week of 01/05/2015. [14-50928] (GAM)
11/03/2014	APPELLANTS BRIEF FILED by Mr. David Lakey and Ms. Mari Robinson. Date of service: 11/03/2014 via email—Attorney for Appellants Cross-Appellees: Klusmann, Mitchell, Murphy, Oldham; Attorney for Appellees Cross-Appellants: Bhandari, Brown, Lawrence, Soifer, Toti; US mail—Attorney for Appellee Cross-Appellant: Gizaw [14-50928] REVIEWED AND/OR EDITED. # of Copies Provided: 0 A/Pet's Brief deadline satisfied. Paper Copies of Brief due on 11/10/2014 for Appellants Cross-Appellees David Lakey and Mari Robinson. [14-50928] (Jonathan F. Mitchell)
11/04/2014	RECORD EXCERPTS FILED by Appellants Cross-Appellees Mr. David Lakey and Ms. Mari Robinson. Date of service: 11/04/2014 via email—Attorney for Appellants Cross-Appellees: Klusmann, Mitchell, Murphy, Oldham; Attorney for Appellees Cross-Appellants: Bhandari, Brown, Lawrence, Soifer, Toti; US mail—Attorney for Appellee Cross-Appellant: Gizaw [14-50928] REVIEWED AND/OR EDITED. # of Copies Provided: 0 Paper Copies of Record Excerpts due on 11/10/2014 for Appellants Cross-Appellees David Lakey and Mari Robinson. [14-50928] (Jonathan F. Mitchell)

11/04/2014 Exhibits, 1 Box (Containing 1 Binder of Supplemental Plaintiffs' & Defendants' Deposition Excerpts), FILED [14-50928] (MVM)

11/05/2014 Paper copies of appellant brief filed by Appellants Cross-Appellees Ms. Mari Robinson and Mr. David Lakey in 14-50928 received. Paper copies match electronic version of document? Yes. # of Copies Provided: 7. Paper Copies of Brief due deadline satisfied. [14-50928] (RJd)

11/05/2014 Paper copies of record excerpts filed by Appellants Cross-Appellees Ms. Mari Robinson and Mr. David Lakey in 14-50928 received. Paper copies match electronic version of document? Yes # of Copies Provided: 4. Paper Copies of Record Excerpts due deadline satisfied. [14-50928] (RJd)

11/05/2014 RECORD ON APPEAL FORWARDED. [14-50928] (MVM)

11/10/2014 AMICUS CURIAE BRIEF FILED by Mr. John M. Zerwas, Mr. Paul Workman, Mr. James White, Mr. Drew Springer, Mr. John Smithee, Mr. Ron Simmons, Mr. David Simpson, Mr. Kenneth Sheets, Ms. Debbie Riddle, Mr. Chris Paddie, Mr. Rick Miller, Mr. Douglas Miller, Ms. Geanie Morrison, Ms. Jodie Laubenberg, Mr. Jeff Leach, Mr. Lyle Larson, Mr. Matt Krause, Mr. Philip King, Mr. John Keumpel, Mr. James Keffer, Mr. Kyle Kacal, Mr. Jason Isaac, Mr. Todd Hunter, Ms. Linda Harper-Brown, Mr.

John Frullo, Mr. Dan Flynn, Mr. Tony Dale, Ms. Myra Crownover, Mr. Travis Paul Clardy, Ms. Angie Chen-Button, Ms. Cindy Burkett, Mr. Dwayne Bohac, Mr. Cecil Bell, Jr., Mr. Jimmie Don Aycock, Mr. Trent Ashby, Mr. Larry Taylor, Mr. Kel Seliger, Mr. Charles Schwertner, Mr. Charles Perry, Mr. Robert Nichols, Ms. Kelly Hancock, Mr. Craig Estes, Mr. Bob Deuell and Mr. John Carona.

The Consent is included in the Brief.

Additionally the Brief requires title does not agree with the caption of the case. Instructions to Attorney: PLEASE READ THE ATTACHED NOTICE FOR INSTRUCTIONS ON HOW TO REMEDY THE DEFAULT.

# of Copies Provided: 0

Sufficient Brief due on 11/24/2014 for Amici Curiae John Carona, Bob Deuell, Craig Estes, Kelly Hancock, Robert Nichols, Charles Perry, Charles Schwertner, Kel Seliger, Larry Taylor, Trent Ashby, Jimmie Don Aycock, Cecil Bell, Dwayne Bohac, Cindy Burkett, Angie Chen-Button, Travis Paul Clardy, Myra Crownover, Tony Dale, Dan Flynn, John Frullo, Linda Harper-Brown, Todd Hunter, Jason Isaac, Kyle Kacal, James Keffer, John Keumpel, Philip King, Matt Krause, Lyle Larson, Jeff Leach, Jodie Laubenberg, Geanie Morrison, Douglas

	Miller, Rick Miller, Chris Paddie, Debbie Riddle, Kenneth Sheets, David Simpson, Ron Simmons, John Smithee, Drew Springer, James White, Paul Workman and John M. Zerwas. [14-50928] RE-VIEWED AND/OR EDITED—AMICUS CURIAE BRIEF FILED by 44 Texas Legislators. Date of service: 11/10/2014 via email—Attorney for Appellants Cross-Appellees: Klusmann, Mitchell, Murphy, Oldham; Attorney for Appellees Cross-Appellants: Bhandari, Brown, Lawrence, Soifer, Toti; US mail—Attorney for Appellee Cross-Appellant: Gizaw [14-50928] (Mailee Rebecca Smith)
11/10/2014	AMICUS CURIAE BRIEF FILED by Houston Coalition for Life and American Center for Law and Justice. The Consent is included in the Brief. # of Copies Provided: 0 Paper Copies of Brief due on 11/17/2014 for Amici Curiae American Center for Law and Justice and Houston Coalition for Life. [14-50928] REVIEWED AND/OR EDITED—AMICUS CURIAE BRIEF FILED by American Center for Law & Justice and Houston Coalition for Life. Date of service: 11/10/2014 via email—Attorney for Appellants Cross-Appellees: Klusmann, Mitchell, Murphy, Oldham; Attorney for Appellees Cross-Appellants: Bhandari, Brown, Gizaw, Lawrence, Soifer, Toti; US mail—Attorney for

Appellee Cross-Appellant: Gizaw [14-50928] (Walter Martin Weber)

11/10/2014 AMICUS CURIAE BRIEF FILED by The Heidi Group, Ms. Carol Everett, And Then There Were None, Ms. Abby Johnson, Texas Center for Defense of Life, Life Legal Defense Foundation, Ms. Donna Harrison, American Association of Pro-Life Obstetricians & Gynecologists and Alliance Defending Freedom. The Consent is Included in the Brief.

# of Copies Provided: 0

Paper Copies of Brief due on 11/17/2014 for Amici Curiae Alliance Defending Freedom, American Association of Pro-Life Obstetricians & Gynecologists, Donna Harrison, Life Legal Defense Foundation, Texas Center for Defense of Life, Abby Kristen Johnson, And Then There Were None, Carol Everett and Heidi Group. [14-50928]

REVIEWED AND/OR EDITED—The original text prior to review appeared as follows: AMICUS CURIAE BRIEF FILED by Michael J. Norton. Date of service: 11/10/2014 via email—Attorney for Amici Curiae: Heil, Roth, Sekulow, Smith, Weber; Attorney for Appellants Cross-Appellees: Klusmann, Mitchell, Murphy, Oldham; Attorney for Appellees Cross-Appellants: Bhandari, Brown, Gizaw, Lawrence, Soifer, Toti [1450928] (Michael J. Norton)

11/10/2014 APPEARANCE FORM FILED by Attorney Mailee Rebecca Smith for Amicus Curiae John M. Zerwas in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Paul Workman in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae James White in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Drew Springer in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae John Smithee in 1450928, Attorney Mailee Rebecca Smith for Amicus Curiae Ron Simmons in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae David Simpson in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Kenneth Sheets in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Debbie Riddle in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Chris Paddie in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Rick Miller in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Douglas Miller in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Geanie Morrison in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Jodie Laubenberg in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Jeff Leach in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Lyle Larson in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Matt Krause in 14-50928, Attorney Mailee

Rebecca Smith for Amicus Curiae Philip King in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae John Keumpel in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae James Keffer in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Kyle Kacal in 1450928, Attorney Mailee Rebecca Smith for Amicus Curiae Jason Isaac in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Todd Hunter in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Linda Harper-Brown in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae John Frullo in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Dan Flynn in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Tony Dale in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Myra Crownover in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Travis Paul Clardy in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Angie Chen-Button in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Cindy Burkett in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Dwayne Bohac in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Cecil Bell Jr. in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Jimmie Don Aycock in 14-50928, Attorney Mailee Rebecca

	Smith for Amicus Curiae Trent Ashby in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Larry Taylor in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Kel Seliger in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Charles Schwertner in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Charles Perry in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Robert Nichols in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Kelly Hancock in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Craig Estes in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae Bob Deuell in 14-50928, Attorney Mailee Rebecca Smith for Amicus Curiae John Carona in 14-50928 Sufficient Brief deadline satisfied [14-50928] (RLL)
11/10/2014	AMICUS CURIAE BRIEF FILED by Eagle Forum Education and Legal Defense Fund, Texas Right to Life, Association of American Physicians & Surgeons, Incorporated, Texas Eagle Forum, Mr. Don Huffines, Mr. Bob Hall, Ms. Jane Nelson, Mr. Eddie Lucio, Jr., Mr. Glenn Hegar, Jr., Mr. Troy Fraser, Mr. Brandon Creighton, Ms. Donna Campbell, Mr. Brian Birdwell, Mr. John Wray, Ms. Molly S. White, Mr. Stuart Spitzer, Mr. Matt Shaheen, Mr. Mike Schofield, Mr. Matt Rinaldi, Mr. Dade Phelan, Mr. Brooks Landgraf, Mr. Mark

Keough, Mr. Wayne Faircloth, Mr. Rodney Anderson, Mr. Bill Zedler, Mr. Scott Turner, Mr. Steve Toth, Mr. Ed Thompson, Mr. Jonathan Stickland, Mr. Matt Schaefer, Mr. Scott Sanford, Mr. Jim Pitts, Mr. Larry Phillips, Mr. Tan Parker, Mr. John Otto, Mr. Jim Murphy, Mr. George Lavender, Ms. Stephanie Klick, Mr. Bryan Hughes, Mr. James Frank, Mr. Allen Fletcher, Mr. Pat Fallon, Mr. John E. Davis, Mr. Giovanni Capriglione, Mr. Greg Bonnen, Mr. Dennis Bonnen, Mr. Charles Anderson, Mr. Cecil Bell, Jr., Mr. Dwayne Bohac, Ms. Cindy Burkett, Mr. John Carona, Mr. Bob Deuell, Mr. Craig Estes, Mr. Dan Flynn, Ms. Kelly Hancock, Ms. Linda Harper-Brown, Mr. Jason Isaac, Mr. Philip King, Mr. Matt Krause, Ms. Jodie Laubenberg, Mr. Jeff Leach, Mr. Rick Miller, Mr. Robert Nichols, Mr. Chris Paddie, Mr. Charles Perry, Mr. Charles Schwertner, Mr. Ron Simmons, Mr. David Simpson, Mr. John Smithee, Mr. Drew Springer, Mr. Larry Taylor, Mr. James White and Mr. Paul Workman.

The Consent is Included in the Brief.

# of Copies Provided: 0

Paper Copies of Brief due on 11/24/2014 for Amici Curiae Charles Anderson, Dennis Bonnen, Greg Bonnen, Giovanni Capriglione, John E. Davis, Pat Fallon, Allen Fletcher, James Frank, Bryan Hughes, Stephanie Klick, George Lavender,

Jim Murphy, John Otto, Tan Parker, Larry Phillips, Jim Pitts, Scott Sanford, Matt Schaefer, Jonathan Stickland, Ed Thompson, Steve Toth, Scott Turner, Bill Zedler, Rodney Anderson, Wayne Faircloth, Mark Keough, Brooks Landgraf, Dade Phelan, Matt Rinaldi, Mike Schofield, Matt Shaheen, Stuart Spitzer, Molly S. White, John Wray, Brian Birdwell, Donna Campbell, Brandon Creighton, Troy Fraser, Glenn Hegar, Eddie Lucio, Jane Nelson, Bob Hall, Don Huffines, Texas Eagle Forum, Association of American Physicians & Surgeons, Incorporated, Texas Right to Life, Eagle Forum Education and Legal Defense Fund, Cecil Bell Jr., Dwayne Bohac, Cindy Burkett, John Carona, Bob Deuell, Craig Estes, Dan Flynn, Kelly Hancock, Linda Harper-Brown, Jason Isaac, Philip King, Matt Krause, Jodie Laubenberg, Jeff Leach, Rick Miller, Robert Nichols, Chris Paddie, Charles Perry, Charles Schwertner, Ron Simmons, David Simpson, John Smithee, Drew Springer, Larry Taylor, James White and Paul Workman. [14-50928]

REVIEWED AND/OR EDITED—The original text prior to review appeared as follows: AMICUS CURIAE BRIEF FILED by 68 Texas State Legislators and 4 public-interest groups: Texas State Reps. Charles Doc Anderson, Cecil Bell, Jr., Dwayne Bohac, Dennis Bonnen, Greg Bonnen, M.D., Cindy Burkett, Giovanni

Capriglione, John E. Davis, . . . (full list with Appearance. Date of service: 11/10/2014 via email—Attorney for Amici Curiae: Aden, Decker, Foster, Norton, Sekulow, Smith, Weber; Attorney for Appellants Cross-Appellees: Klusmann, Mitchell, Murphy, Oldham; Attorney for Appellees Cross-Appellants: Bhandari, Brown, Lawrence, Soifer, Toti; US mail—Attorney for Amici Curiae: Casey, Heil, Roth, Short, Terra; Attorney for Appellee Cross-Appellant: Gizaw [14-50928] (Lawrence John Joseph)

11/10/2014 DOCUMENT RECEIVED—NO ACTION TAKEN. No action will be taken at this time on the motion for leave to file an amicus brief received from Not Parties Ms. Dawn Milberger and Women Injured By Abortion because motion is not needed as consent has been given. See 11/12/14 letter [14-50928] (MVM)

11/10/2014 AMICUS CURIAE BRIEF FILED by Ms. Dawn Milberger and Women Injured By Abortion. The Consent is Included in the Brief.

Brief NOT Sufficient as it requires an Appearance Form from counsel signing the brief. Additionally the title does not agree with the caption of the case. Instructions to Attorney: PLEASE READ THE ATTACHED NOTICE FOR INSTRUCTIONS ON HOW TO REMEDY THE DEFAULT. # of Copies Provided: 0 Sufficient Brief due on 12/01/2014 for

Amici Curiae Women Injured By Abortion and Dawn Milberger. [1450928] (MVM)

11/12/2014 APPEARANCE FORM FILED by Attorney Michael J. Norton for Amicus Curiae Heidi Group in 14-50928, Attorney Michael J. Norton for Amicus Curiae And Then There Were None in 14-50928, Attorney Michael J. Norton for Amicus Curiae Abby Kristen Johnson in 14-50928, Attorney Michael J. Norton for Amicus Curiae Texas Center for Defense of Life in 14-50928, Attorney Michael J. Norton for Amicus Curiae Life Legal Defense Foundation in 14-50928, Attorney Michael J. Norton for Amicus Curiae Donna Harrison in 1450928, Attorney Michael J. Norton for Amicus Curiae American Association of Pro-Life Obstetricians & Gynecologists in 14-50928, Attorney Michael J. Norton for Amicus Curiae Alliance Defending Freedom in 14-50928 [14-50928] (RSM)

11/12/2014 APPEARANCE FORM FILED by Attorney Walter Martin Weber for Amicus Curiae Houston Coalition for Life in 14-50928, Attorney Walter Martin Weber for Amicus Curiae American Center for Law and Justice in 14-50928 [14-50928] (MAS)

11/12/2014 Attorney Ms. Natalie Lynn Decker for Amici Curiae Ms. Abby Kristen Johnson, American Association of Pro-Life Obstetricians & Gynecologists, Alliance Defending Freedom, Texas Center for Defense of Life, Mr. Donna Harrison, Life Legal

Defense Foundation, And Then There Were None, Ms. Carol Everett and Heidi Group is advised to resubmit appearance form. Reason: The submitted appearance form does not match the registered attorney. [14-50928] (LBM)

11/12/2014 LETTER filed referencing amicus brief [7773818-2], motion to file amicus brief [7773807-2]. CONSENT to brief of amici Women Injured by Abortion and an Abortion Survivor. [14-50928] (MBC)

11/14/2014 BRIEF MADE SUFFICIENT filed by Mr. Lyle Larson, Mr. John M. Zerwas, Mr. Travis Paul Clardy, Mr. Robert Nichols, Mr. Ron Simmons, Mr. Rick Miller, Mr. David Simpson, Mr. John Smithee, Mr. Todd Hunter, Mr. Philip King, Mr. Douglas Miller, Mr. Larry Taylor, Mr. James White, Mr. Cecil Bell, Jr., Mr. Dwayne Bohac, Ms. Cindy Burkett, Mr. Tony Dale, Mr. Dan Flynn, Ms. Linda Harper-Brown, Mr. Jason Isaac, Mr. Matt Krause, Ms. Jodie Laubenberg, Mr. Jeff Leach, Mr. Chris Paddie, Mr. Charles Perry, Mr. Drew Springer, Mr. Paul Workman, Mr. John Carona, Mr. Bob Deuell, Mr. Craig Estes, Ms. Kelly Hancock, Mr. Charles Schwertner, Mr. Kel Seliger, Mr. Trent Ashby, Mr. Jimmie Don Aycock, Ms. Angie Chen-Button, Ms. Myra Crownover, Mr. John Frullo, Mr. Kyle Kacal, Mr. James Keffer, Mr. John Keumpel, Ms. Geanie Morrison, Ms.

Debbie Riddle and Mr. Kenneth Sheets in 14-50928 [7772684-2]. Paper Copies of Brief due on 11/19/2014 for Amici Curiae Trent Ashby, Jimmie Don Aycock, Cecil Bell Jr., Dwayne Bohac, Cindy Burkett, John Carona, Angie Chen-Button, Travis Paul Clardy, Myra Crownover, Tony Dale, Bob Deuell, Craig Estes, Dan Flynn, John Frullo, Kelly Hancock, Linda Harper-Brown, Todd Hunter, Jason Isaac, Kyle Kacal, James Keffer, John Keumpel, Philip King, Matt Krause, Lyle Larson, Jodie Laubenberg, Jeff Leach, Douglas Miller, Rick Miller, Geanie Morrison, Robert Nichols, Chris Paddie, Charles Perry, Debbie Riddle, Charles Schwertner, Kel Seliger, Kenneth Sheets, Ron Simmons, David Simpson, John Smithee, Drew Springer, Larry Taylor, James White, Paul Workman and John M. Zerwas. [14-50928] (MVM)

11/14/2014 Paper copies of amicus brief filed by Ms. Abby Kristen Johnson, American Association of Pro-Life Obstetricians & Gynecologists, Alliance Defending Freedom, Texas Center for Defense of Life, Mr. Donna Harrison, Life Legal Defense Foundation, And Then There Were None, Ms. Carol Everett and Heidi Group in 14-50928 received. Paper copies match electronic version of document? Yes # of Copies Provided: 7. Paper Copies of Brief due deadline satisfied. [14-50928] (MVM)

11/17/2014	Paper copies of amicus brief filed by American Center for Law and Justice and Houston Coalition for Life in 14-50928 received. Paper copies match electronic version of document? Yes # of Copies Provided: 7. Paper Copies of Brief due deadline satisfied. [14-50928] (MVM)
11/17/2014	UNOPPOSED MOTION by 68 TEXAS STATE LEGISLATORS AND 4 PUBLIC-INTEREST GROUPS to file amicus brief [7778430-2] Date of service: 11/17/2014 via email—Attorney for Amici Curiae: Aden, Casey, Decker, Foster, Norton, Parker, Sekulow, Smith, Weber; Attorney for Appellants Cross-Appellees: Klusmann, Mitchell, Murphy, Oldham; Attorney for Appellees Cross-Appellants: Bhandari, Brown, Lawrence, Soifer, Toti; US mail—Attorney for Amici Curiae: Heil, Roth, Short, Terra; Attorney for Appellee Cross-Appellant: Gizaw [14-50928] (Lawrence John Joseph)
11/18/2014	CASE CALENDARED for oral argument on Thursday, 01/08/2015 in New Orleans in the East Courtroom—AM session. In accordance with our policy, lead counsel only will receive via email at a later date a copy of the court's docket and an acknowledgment form. All other counsel of record should monitor the court's website for the posting of the oral argument calendars.. [14-50928] (PFT)
11/19/2014	COURT ORDER granting the unopposed motion of 68 Texas state legislators and

four public interest groups, for leave to file amici curiae brief with overlapping legislators joined in the brief [7778430-2] [14-50928] (MVM)

11/19/2014 CASE CAPTION updated. Amicus Curiae Van Taylor added to case. [14-50928] (MVM)

11/19/2014 APPEARANCE FORM FILED by Attorney Lawrence John Joseph for Amicus Curiae Van Taylor in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Eagle Forum Education and Legal Defense Fund in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Texas Right to Life in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Association of American Physicians & Surgeons, Incorporated in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Texas Eagle Forum in 1450928, Attorney Lawrence John Joseph for Amicus Curiae Don Huffines in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Bob Hall in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Jane Nelson in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Eddie Lucio Jr. in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Glenn Hegar Jr. in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Troy Fraser in 14-50928, Attorney Lawrence John Joseph

for Amicus Curiae Brandon Creighton in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Donna Campbell in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Brian Birdwell in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae John Wray in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Molly S. White in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Stuart Spitzer in 1450928, Attorney Lawrence John Joseph for Amicus Curiae Matt Shaheen in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Mike Schofield in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Matt Rinaldi in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Dade Phelan in 1450928, Attorney Lawrence John Joseph for Amicus Curiae Brooks Landgraf in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Mark Keough in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Wayne Faircloth in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Rodney Anderson in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Bill Zedler in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Scott Turner in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Steve Toth in

14-50928, Attorney Lawrence John Joseph for Amicus Curiae Ed Thompson in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Jonathan Stickland in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Matt Schaefer in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Scott Sanford in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Jim Pitts in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Larry Phillips in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Tan Parker in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae John Otto in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Jim Murphy in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae George Lavender in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Stephanie Klick in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Bryan Hughes in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae James Frank in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Allen Fletcher in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Pat Fallon in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae John E. Davis in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Giovanni Capriglione

	in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Greg Bonnen in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Dennis Bonnen in 14-50928, Attorney Lawrence John Joseph for Amicus Curiae Charles Anderson in 14-50928 [14-50928] (RLL)
11/20/2014	APPEARANCE FORM FILED by Attorney Allan Edward Parker Jr. for Amicus Curiae Dawn Milberger in 14-50928, Attorney Allan Edward Parker Jr. for Amicus Curiae Women Injured By Abortion in 14-50928 [14-50928] (MVM)
11/20/2014	Paper copies of amicus brief filed by Mr. Lyle Larson, Mr. John M. Zerwas, Mr. Travis Paul Clardy, Mr. Robert Nichols, Mr. Ron Simmons, Mr. Rick Miller, Mr. David Simpson, Mr. John Smithee, Mr. Todd Hunter, Mr. Philip King, Mr. Douglas Miller, Mr. Larry Taylor, Mr. James White, Mr. Cecil Bell, Jr., Mr. Dwayne Bohac, Ms. Cindy Burkett, Mr. Tony Dale, Mr. Dan Flynn, Ms. Linda Harper-Brown, Mr. Jason Isaac, Mr. Matt Krause, Ms. Jodie Laubenberg, Mr. Jeff Leach, Mr. Chris Paddie, Mr. Charles Perry, Mr. Drew Springer, Mr. Paul Workman, Mr. John Carona, Mr. Bob Deuell, Mr. Craig Estes, Ms. Kelly Hancock, Mr. Charles Schwertner, Mr. Kel Seliger, Mr. Trent Ashby, Mr. Jimmie Don Aycock, Ms. Angie Chen-Button, Ms. Myra Crownover, Mr. John Frullo, Mr. Kyle Kacal, Mr. James Keffer, Mr. John

Keumpel, Ms. Geanie Morrison, Ms. Debbie Riddle, Mr. Kenneth Sheets, Mr. Cecil Bell, Jr., Mr. Dwayne Bohac, Ms. Cindy Burkett, Mr. Dan Flynn, Ms. Linda Harper-Brown, Mr. Jason Isaac, Mr. Phil King, Mr. Matt Krause, Ms. Jodie Laubenberg, Mr. Jeff Leach, Mr. Rick Miller, Mr. Chris Paddie, Mr. Ron Simmons, Mr. David Simpson, Mr. John T. Smithee, Mr. Drew Springer, Mr. James White, Mr. Paul Workman, Mr. John Carona, Mr. Bob Deuell, Mr. Craig Estes, Ms. Kelly Hancock, Mr. Robert Nichols, Mr. Charles Perry, Mr. Charles Schwertner, and Mr. Larry Taylor in 14-50928 received. Paper copies match electronic version of document? Yes # of Copies Provided: 7. Paper Copies of Brief due deadline satisfied. [14-50928] (MVM)

11/20/2014 BRIEF MADE SUFFICIENT filed by Women Injured By Abortion and Ms. Dawn Milberger in 14-50928 [7777288-2]. Sufficient Brief deadline satisfied [14-50928] (MVM)

11/24/2014 Paper copies of amicus brief filed by 70 Texas Legislators and 4 Public-Interest Groups—Mr. Troy Fraser, Ms. Jane Nelson, Association of American Physicians & Surgeons, Incorporated, Mr. Eddie Lucio, Jr., Eagle Forum Education and Legal Defense Fund, Texas Eagle Forum, Mr. Scott Turner, Mr. Dennis Bonnen, Mr. Greg Bonnen, Mr. Giovanni Capriglione, Mr. John E. Davis, Mr. Pat

Fallon, Mr. Allen Fletcher, Mr. James Frank, Mr. Bryan Hughes, Ms. Stephanie Klick, Mr. George Lavender, Mr. Jim Murphy, Mr. John Otto, Mr. Tan Parker, Mr. Larry Phillips, Mr. Jim Pitts, Mr. Scott Sanford, Mr. Matt Schaefer, Mr. Jonathan Stickland, Mr. Ed Thompson, Mr. Steve Toth, Mr. Bill Zedler, Mr. Brian Birdwell, Ms. Donna Campbell, Mr. Glenn Hegar, Jr., Texas Right to Life, Mr. Charles Anderson, Mr. Rodney Anderson, Mr. Wayne Faircloth, Mr. Mark Keough, Mr. Brooks Landgraf, Mr. Dade Phelan, Mr. Matt Rinaldi, Mr. Mike Schofield, Mr. Matt Shaheen, Mr. Stuart Spitzer, Ms. Molly S. White, Mr. John Wray, Mr. Brandon Creighton, Mr. Bob Hall, Mr. Don Huffines and Amici Curiae Mr. Robert Nichols, Mr. Ron Simmons, Mr. Rick Miller, Mr. David Simpson, Mr. John Smithee, Mr. Philip King, Mr. Larry Taylor, Mr. James White, Mr. Cecil Bell, Jr., Mr. Dwayne Bohac, Ms. Cindy Burkett, Mr. Dan Flynn, Ms. Linda Harper-Brown, Mr. Jason Isaac, Mr. Matt Krause, Ms. Jodie Laubenberg, Mr. Jeff Leach, Mr. Chris Paddie, Mr. Charles Perry, Mr. Drew Springer, Mr. Paul Workman, Mr. John Carona, Mr. Bob Deuell, Mr. Craig Estes, Ms. Kelly Hancock and Mr. Charles Schwertner in 14-50928 received. Paper copies match electronic version of document? Yes # of Copies Provided: 7.

Paper Copies of Brief due deadline satisfied. [14-50928] (MVM)

11/24/2014 CROSS APPELLANT'S BRIEF FILED # of Copies Provided: 0 XA/Pet Brief deadline satisfied. Paper Copies of Brief due on 12/01/2014 for Appellees Cross-Appellants Austin Women's Health Center, Lendol L. Davis, Killeen Women's Health Center, Sherwood C. Lynn Jr., Nova Health Systems, Pamela J. Richter and Whole Woman's Health. [14-50928]

REVIEWED AND/OR EDITED—The original text prior to review appeared as follows: APPELLEE'S BRIEF FILED by Appellees Cross-Appellants Austin Women's Health Center, Mr. Lendol L. Davis, Killeen Women's Health Center, Mr. Sherwood C. Lynn, Jr., Nova Health Systems, Ms. Pamela J. Richter and Whole Woman's Health. Date of service: 11/24/2014 via email—Attorney for Amici Curiae: Aden, Casey, Decker, Foster, Heil, Joseph, Norton, Parker, Roth, Sekulow, Short, Smith, Terra, Weber; Attorney for Appellants Cross-Appellees: Klusmann, Mitchell, Murphy, Oldham; Attorney for Appellees Cross-Appellants: Bhandari, Brown, Gizaw, Lawrence, Soifer, Toti [14-50928] (Stephanie Toti)

11/24/2014 RECORD EXCERPTS FILED. # of Copies Provided: 0 Paper Copies of Record Excerpts due on 12/01/2014 for Appellees Cross-Appellants Austin Women's Health

Center, Lendol L. Davis, Killeen Women's Health Center, Sherwood C. Lynn Jr., Nova Health Systems, Pamela J. Richter and Whole Woman's Health. [14-50928]

REVIEWED AND/OR EDITED—The original text prior to review appeared as follows: RECORD EXCERPTS FILED by Appellees Cross-Appellants Austin Women's Health Center, Mr. Lendol L. Davis, Killeen Women's Health Center, Mr. Sherwood C. Lynn, Jr., Nova Health Systems, Ms. Pamela J. Richter and Whole Woman's Health. Date of service: 11/24/2014 via email—Attorney for Amici Curiae: Aden, Casey, Decker, Foster, Heil, Joseph, Norton, Parker, Roth, Sekulow, Short, Smith, Terra, Weber; Attorney for Appellants Cross-Appellees: Klusmann, Mitchell, Murphy, Oldham; Attorney for Appellees Cross-Appellants: Bhandari, Brown, Gizaw, Lawrence, Soifer, Toti [14-50928] (Stephanie Toti)

11/25/2014 Paper copies of amicus brief filed by Women Injured By Abortion and Ms. Dawn Milberger in 14-50928 received. Paper copies match electronic version of document? Yes # of Copies Provided: 7. [14-50928] (MVM)

11/25/2014 APPEARANCE FORM FILED by Attorney Kimberly A. Parker for Amicus Curiae American Medical Association in 14-50928, Attorney Kimberly A. Parker for Amicus Curiae American College of

	Obstetricians and Gynecologists in 14-50928 [14-50928] (MVM)
12/01/2014	AMICUS CURIAE BRIEF FILED by Planned Parenthood South Texas Surgical Center, Planned Parenthood of Greater Texas Surgical Health Services and Planned Parenthood Center for Choice. The Consent is Included in the Brief. # of Copies Provided: 0 Paper Copies of Brief due on 12/08/2014 for Amici Curiae Planned Parenthood Center for Choice, Planned Parenthood of Greater Texas Surgical Health Services and Planned Parenthood South Texas Surgical Center. [14-50928] REVIEWED AND/OR EDITED—The original text prior to review appeared as follows: AMICUS CURIAE BRIEF FILED by Planned Parenthood Center for Choice, Planned Parenthood of Greater Texas Surgical Health Services, and Planned Parenthood South Texas Surgical Center. in support of Plaintiffs/Appellees/Cross-Appellants Date of service: 12/01/2014 via email—Attorney for Amici Curiae: Aden, Casey, Decker, Foster, Heil, Joseph, Norton, Parker, Roth, Sekulow, Short, Smith, Terra, Weber; Attorney for Appellants Cross-Appellees: Klusmann, Mitchell, Murphy, Oldham; Attorney for Appellees Cross-Appellants: Bhandari, Brown, Gizaw,

	Lawrence, Soifer, Toti [14-50928] (Carrie Yvette Flaxman)
12/01/2014	AMICUS CURIAE BRIEF FILED by American Medical Association and American College of Obstetricians and Gynecologists. The Consent is Included in the Brief. # of Copies Provided: 0 Paper Copies of Brief due on 12/08/2014 for Amici Curiae American College of Obstetricians and Gynecologists and American Medical Association. [14-50928] REVIEWED AND/OR EDITED—The original text prior to review appeared as follows: AMICUS CURIAE BRIEF FILED by American College of Obstetricians and Gynecologists, and The American Medical Association. Date of service: 12/01/2014 via email—Attorney for Amici Curiae: Aden, Casey, Decker, Foster, Heil, Joseph, Norton, Parker, Roth, Sekulow, Short, Smith, Terra, Weber; Attorney for Appellants Cross-Appellees: Klusmann, Mitchell, Murphy, Oldham; Attorney for Appellees Cross-Appellants: Bhandari, Brown, Gizaw, Lawrence, Soifer, Toti [14-50928] (Kimberly A. Parker)
12/01/2014	APPEARANCE FORM FILED by Attorney Carrie Yvette Flaxman for Amicus Curiae Planned Parenthood South Texas Surgical Center in 14-50928, Attorney Carrie Yvette Flaxman for Amicus

Curiae Planned Parenthood of Greater Texas Surgical Health Services in 14-50928, Attorney Carrie Yvette Flaxman for Amicus Curiae Planned Parenthood Center for Choice in 14-50928 [14-50928] (MVM)

12/01/2014 Paper copies of cross appellant brief filed by Appellees Cross-Appellants Whole Woman's Health, Ms. Pamela J. Richter, Austin Women's Health Center, Killeen Women's Health Center, Nova Health Systems, Mr. Sherwood C. Lynn, Jr. and Mr. Lendol L. Davis in 14-50928 received. Paper copies match electronic version of document? Yes # of Copies Provided: 7. Paper Copies of Brief due deadline satisfied. [1450928] (MVM)

12/01/2014 Paper copies of record excerpts filed by Appellees Cross-Appellants Whole Woman's Health, Ms. Pamela J. Richter, Austin Women's Health Center, Killeen Women's Health Center, Nova Health Systems, Mr. Sherwood C. Lynn, Jr. and Mr. Lendol L. Davis in 14-50928 received. Paper copies match electronic version of document? Yes # of Copies Provided: 4. Paper Copies of Record Excerpts due deadline satisfied. [14-50928] (MVM)

12/01/2014 CROSS APPELLEE'S BRIEF FILED # of Copies Provided: 0 XE/Res Brief deadline satisfied. Paper Copies of Brief due on 12/08/2014 for Appellants

Cross-Appellees David Lakey and Mari Robinson. [1450928]

REVIEWED AND/OR EDITED—The original text prior to review appeared as follows: APPELLANT'S REPLY BRIEF FILED by Mr. David Lakey and Ms. Mari Robinson Date of service: 12/01/2014 via email—Attorney for Amici Curiae: Aden, Casey, Decker, Flaxman, Foster, Joseph, Norton, Parker, Parker, Sekulow, Smith, Weber; Attorney for Appellants Cross-Appellees: Klusmann, Mitchell, Murphy, Oldham; Attorney for Appellees Cross-Appellants: Bhandari, Brown, Lawrence, Soifer, Toti; US mail—Attorney for Amici Curiae: Heil, Roth, Short, Terra; Attorney for Appellee Cross-Appellant: Gizaw [14-50928] (Jonathan F. Mitchell)

12/03/2014 Paper copies of amicus brief filed by American Medical Association and American College of Obstetricians and Gynecologists in 14-50928 received. Paper copies match electronic version of document? Yes # of Copies Provided: 7. Paper Copies of Brief due deadline satisfied. [14-50928] (MVM)

12/03/2014 Paper copies of cross appellee brief filed by Appellants Cross-Appellees Ms. Mari Robinson and Mr. David Lakey in 14-50928 received. Paper copies match electronic version of document? Yes # of Copies Provided: 7. Paper Copies of

Brief due deadline satisfied. [14-50928] (MVM)

12/03/2014 UNOPPOSED MOTION filed by Amici Curiae Planned Parenthood Center for Choice, Planned Parenthood South Texas Surgical Center and Planned Parenthood of Greater Texas Surgical Health Services to file corrected amicus brief [7789826-2]. Date of service: 12/03/2014 [14-50928]

REVIEWED AND/OR EDITED—The original text prior to review appeared as follows: UNOPPOSED MOTION to file corrected amicus brief [7789826-3] [14-50928] REVIEWED AND/OR EDITED—The original text prior to review appeared as follows: UNOPPOSED MOTION by Planned Parenthood Center for Choice, Planned Parenthood of Greater Texas Surgical Health Services, and Planned Parenthood South Texas Surgical Center to file corrected amicus brief [7789826-2] Date of service: 12/03/2014 via email -Attorney for Amici Curiae: Aden, Casey, Decker, Flaxman, Foster, Heil, Joseph, Norton, Parker, Parker, Roth, Sekulow, Short, Smith, Terra, Weber; Attorney for Appellants Cross-Appellees: Klusmann, Mitchell, Murphy, Oldham; Attorney for Appellees Cross-Appellants: Bhandari, Brown, Gizaw, Lawrence, Soifer, Toti [14-50928] (Carrie Yvette Flaxman)

12/05/2014	CLERK ORDER granting motion to file corrected brief filed by Amici Curiae Planned Parenthood of Greater Texas Surgical Health Services, Planned Parenthood Center for Choice and Planned Parenthood South Texas Surgical Center [7789826-2]; withdrawing amicus brief filed by Planned Parenthood of Greater Texas Surgical Health Services, Planned Parenthood Center for Choice and Planned Parenthood South Texas Surgical Center [7786480-2]. [14-50928] (MVM)
12/05/2014	CORRECTED BRIEF filed by Amici Curiae Planned Parenthood Center for Choice, Planned Parenthood South Texas Surgical Center and Planned Parenthood of Greater Texas Surgical Health Services ..Paper Copies of Brief due on 12/10/2014 for Amici Curiae Planned Parenthood Center for Choice, Planned Parenthood of Greater Texas Surgical Health Services and Planned Parenthood South Texas Surgical Center. [14-50928] (MVM)
12/08/2014	CROSS APPELLANT'S REPLY BRIEF FILED # of Copies Provided: 0 XA/Pet Reply Brief deadline satisfied. Paper Copies of Brief due on 12/15/2014 for Appellees Cross-Appellants Austin Women's Health Center, Lendol L. Davis, Killeen Women's Health Center, Sherwood C. Lynn Jr., Nova Health

Systems, Pamela J. Richter and Whole Woman's Health. [14-50928]

REVIEWED AND/OR EDITED—The original text prior to review appeared as follows: CROSS APPELLANTS REPLY BRIEF FILED by Austin Women's Health Center, Mr. Lendol L. Davis, Killeen Women's Health Center, Mr. Sherwood C. Lynn, Jr., Nova Health Systems, Ms. Pamela J. Richter and Whole Woman's Health Date of service: 12/08/2014 via email—Attorney for Amici Curiae: Aden, Casey, Decker, Flaxman, Foster, Heil, Joseph, Norton, Parker, Parker, Roth, Sekulow, Short, Smith, Terra, Weber; Attorney for Appellants Cross-Appellees: Klusmann, Mitchell, Murphy, Oldham; Attorney for Appellees Cross-Appellants: Bhandari, Brown, Gizaw, Lawrence, Soifer, Toti [14-50928] (Stephanie Toti)

12/09/2014 Paper copies of corrected brief filed by Amici Curiae Planned Parenthood of Greater Texas Surgical Health Services, Planned Parenthood Center for Choice and Planned Parenthood South Texas Surgical Center in 14-50928 received. Paper copies match electronic version of document? Yes # of Copies Provided: 7. Paper Copies of Brief due deadline satisfied. [14-50928] (MVM)

12/11/2014 Paper copies of appellant reply brief filed by Appellees Cross-Appellants Whole Woman's Health, Ms. Pamela J. Richter,

	Austin Women's Health Center, Killeen Women's Health Center, Nova Health Systems, Mr. Sherwood C. Lynn, Jr. and Mr. Lendol L. Davis in 14-50928 received. Paper copies match electronic version of document? Yes # of Copies Provided: 7. Paper Copies of Brief due deadline satisfied. [1450928] (MVM)
12/31/2014	APPEARANCE FORM FILED by Attorney(s) James Davis Blacklock for party(s) Appellant Cross-Appellee Mari Robinson Appellant Cross-Appellee David Lakey, in case 14-50928 [14-50928] (MVM)
01/07/2015	ORAL ARGUMENT HEARD before Judges Prado, Elrod, Haynes. Arguing Person Information Updated for: Jonathan F. Mitchell arguing for Appellants Cross-Appellees David Lakey and Mari Robinson; Arguing Person Information Updated for: Stephanie Toti arguing for Appellees Cross-Appellants Whole Woman's Health, Austin Women's Health Center, Lendol L. Davis, Killeen Women's Health Center, Sherwood C. Lynn, Jr., Nova Health Systems, Pamela J. Richter [14-50928] (PFT)
01/13/2015	APPEARANCE FORM FILED by Attorney(s) Patrick J. O'Connell for party(s) Appellee Cross-Appellant Nova Health Systems Appellee Cross-Appellant Pamela J. Richter Appellee Cross-Appellant Lendol L. Davis Appellee Cross-Appellant Whole Woman's Health Appellee Cross-Appellant Sherwood C.

	Lynn Jr. Appellee Cross-Appellant Killeen Women's Health Center Appellee Cross-Appellant Austin Women's Health Center, in case 14-50928 [14-50928] (MVM)
01/23/2015	APPEARANCE FORM FILED by Attorney(s) Scott A. Keller for party(s) Appellant Cross-Appellee Mari Robinson Appellant Cross-Appellee David Lakey, in case 14-50928 [14-50928] (MVM)
02/03/2015	ATTORNEY NOT PARTICIPATING. Jonathan Mitchell is designated as inactive in this case. Reason:attorney no longer with office. [14-50928] (MVM)
03/23/2015	SUPPLEMENTAL AUTHORITIES (FRAP 28j) FILED by Appellees Cross-Appellants Austin Women's Health Center, Mr. Lendol L. Davis, Killeen Women's Health Center, Mr. Sherwood C. Lynn, Jr., Nova Health Systems, Ms. Pamela J. Richter and Whole Woman's Health Date of Service: 03/23/2015 via email—Attorney for Amici Curiae: Aden, Casey, Decker, Flaxman, Foster, Heil, Joseph, Norton, Parker, Parker, Roth, Sekulow, Short, Smith, Terra, Weber; Attorney for Appellants Cross-Appellees: Blacklock, Keller, Klusmann, Murphy, Oldham; Attorney for Appellees Cross-Appellants: Bhandari, Brown, Gizaw, Lawrence, O'Connell, Soifer, Toti [14-50928] (Stephanie Toti)
06/09/2015	PUBLISHED OPINION FILED. [14-50928 Affirmed in Part, Modified in Part, Vacated in Part, and Reversed in Part] Judge:

ECP, Judge: JWE, Judge: CH Mandate pull date is 06/30/2015 [14-50928] (DTG)

06/09/2015 LJUDGMENT ENTERED AND FILED. [14-50928] (DTG)

06/09/2015 COSTS TAXED AGAINST: Plaintiffs-appellees-cross-appellants. [14-50928] (DTG)

06/10/2015 MOTION filed by Appellees Cross-Appellants Austin Women's Health Center, Mr. Lendol L. Davis, Killeen Women's Health Center, Mr. Sherwood C. Lynn, Jr., Nova Health Systems, Ms. Pamela J. Richter and Whole Woman's Health to stay issuance of the mandate [7933331-2]. Date of service: 06/10/2015 via email—Attorney for Amici Curiae: Aden, Casey, Decker, Flaxman, Foster, Heil, Joseph, Norton, Parker, Parker, Roth, Sekulow, Short, Smith, Terra, Weber; Attorney for Appellants Cross-Appellees: Blacklock, Keller, Klusmann, Murphy, Oldham; Attorney for Appellees Cross-Appellants: Bhandari, Brown, Gizaw, Lawrence, O'Connell, Soifer, Toti [14-50928] (Stephanie Toti)

06/10/2015 RESPONSE DUE to motion to stay issuance of the mandate filed by Appellees Cross-Appellants Whole Woman's Health, Ms. Pamela J. Richter, Austin Women's Health Center, Killeen Women's Health Center, Nova Health Systems, Mr. Sherwood C. Lynn, Jr. and Mr. Lendol L. Davis in 14-50928

[Response/Opposition due on 06/23/2015 [14-50928] (MBC)

06/11/2015 COURT DIRECTIVE ISSUED requesting a letter from Appellees Cross-Appellants Whole Woman's Health, Ms. Pamela J. Richter, Austin Women's Health Center, Killeen Women's Health Center, Nova Health Systems, Mr. Sherwood C. Lynn, Jr. and Mr. Lendol L. Davis in 14-50928 [7933331-2] Letter/Response/Opposition due on 06/12/2015. Defendants-Appellants shall file a response to the Appellees' Motion to Stay the Mandate, as well as a response to the above-ordered letter, no later than June 15, 2015. [14-50928] (MFY)

06/11/2015 RESPONSE DUE to update/term response deadline [7933526-2]Response/ Opposition deadline updated to 06/15/2015 [14-50928] (for response and letter filed by Apellants)—[Edited 06/11/2015 by MFY] (MFY)

06/12/2015 LETTER filed by Appellees Cross-Appellants Austin Women's Health Center, Mr. Lendol L. Davis, Killeen Women's Health Center, Mr. Sherwood C. Lynn, Jr., Nova Health Systems, Ms. Pamela J. Richter and Whole Woman's Health referencing court order Court directive requesting a response [7934332-2]. Date of Service: 06/12/2015 via email—Attorney for Amici Curiae: Aden, Casey, Decker, Flaxman, Foster, Heil, Joseph, Norton, Parker, Parker, Roth,

Sekulow, Short, Smith, Terra, Weber; Attorney for Appellants Cross-Appellees: Blacklock, Keller, Klusmann, Murphy, Oldham; Attorney for Appellees Cross-Appellants: Bhandari, Brown, Gizaw, Lawrence, O'Connell, Soifer, Toti [14-50928] (Stephanie Toti)

06/15/2015 RESPONSE/OPPOSITION filed by Mr. Kirk Cole, Mr. David Lakey and Ms. Mari Robinson [7937284-1] to the motion to stay issuance of the mandate filed by Appellees Cross-Appellants Whole Woman's Health, Ms. Pamela J. Richter, Austin Women's Health Center, Killeen Women's Health Center, Nova Health Systems, Mr. Sherwood C. Lynn, Jr. and Mr. Lendol L. Davis in 14-50928 [7933331-2] Date of Service: 06/15/2015 via email—Attorney for Amici Curiae: Aden, Casey, Decker, Flaxman, Foster, Joseph, Norton, Parker, Parker, Sekulow, Short, Smith, Weber; Attorney for Appellants Cross-Appellees: Blacklock, Keller, Klusmann, Murphy, Oldham; Attorney for Appellees Cross-Appellants: Bhandari, Brown, Lawrence, O'Connell, Soifer, Toti; US mail—Attorney for Amici Curiae: Heil, Roth, Terra; Attorney for Appellee Cross-Appellant: Gizaw. [14-50928] (Scott A. Keller)

06/15/2015 UNOPPOSED MOTION by Not Parties Texas Alliance for Life, Texans for Life and Texas Values to file amicus brief

[7937287-2] [14-50928] REVIEWED AND/OR EDITED—The original text prior to review appeared as follows: UNOPPOSED MOTION by Texas Alliance for Life, Texans for Life, and Texas Values to file amicus brief [7937287-2] Date of service: 06/15/2015 via email—Attorney for Amici Curiae: Aden, Casey, Decker, Flaxman, Foster, Joseph, Norton, Parker, Parker, Sekulow, Short, Smith, Weber; Attorney for Appellants Cross-Appellees: Blacklock, Keller, Klusmann, Murphy, Oldham; Attorney for Appellees Cross-Appellants: Bhandari, Brown, Lawrence, O'Connell, Soifer, Toti; US mail—Attorney for Amici Curiae: Heil, Roth, Terra; Attorney for Appellee Cross-Appellant: Gizaw [14-50928] (Jonathan F. Mitchell)

06/15/2015 LETTER filed by Appellants Cross-Appellees Mr. Kirk Cole and Ms. Mari Robinson referencing letter filed by Appellees Cross-Appellants Whole Woman's Health, Ms. Pamela J. Richter, Austin Women's Health Center, Killeen Women's Health Center, Nova Health Systems, Mr. Sherwood C. Lynn, Jr. and Mr. Lendol L. Davis in 14-50928 [7935778-2]. Date of Service: 06/15/2015 via email—Attorney for Amici Curiae: Aden, Casey, Decker, Flaxman, Foster, Joseph, Norton, Parker, Parker, Sekulow, Short, Smith, Weber; Attorney for Appellants Cross-Appellees: Blacklock, Keller, Klusmann, Murphy,

Oldham; Attorney for Appellees Cross-Appellants: Bhandari, Brown, Lawrence, O'Connell, Soifer, Toti; US mail—Attorney for Amici Curiae: Heil, Roth, Terra; Attorney for Appellee Cross-Appellant: Gizaw [14-50928] (Scott A. Keller)

06/19/2015 COURT ORDER granting motion to file amicus brief [7937287-2]; denying motion to stay issuance of the mandate filed by Appellees Cross-Appellants Whole Woman's Health, Ms. Pamela J. Richter, Austin Women's Health Center, Killeen Women's Health Center, Nova Health Systems, Mr. Sherwood C. Lynn, Jr. and Mr. Lendol L. Davis [7933331-2]; to modify opinion [7942208-2] Judge(s): ECP, dissenting, JWE and CH. [14-50928] (JRS)

06/19/2015 CASE CAPTION updated. Party information modified for Texas Alliance for Life, Texans for Life and Texas Values in 14-50928. Update: Court order entered allowing as amici parties. [14-50928] (MFY)

06/19/2015 AMICUS CURIAE BRIEF FILED by Texans for Life, Texas Alliance for Life and Texas Values. Consent is Not Necessary as a Motion has been Granted.

# of Copies Provided: 0 [14-50928] (MFY)

06/22/2015 BILL OF COSTS filed by Appellants Cross-Appellees Mr. Kirk Cole and Ms. Mari Robinson. [14-50928] (Scott A. Keller)

06/29/2015 SUPREME COURT ORDER received staying issuance of mandate pending

filing of cert in Supreme Court. [7949525-1] [14-50928] (MBC)

09/09/2015 SUPREME COURT NOTICE that petition for writ of certiorari [8006369-2] was filed by Appellees Cross-Appellants Austin Women's Health Center, Mr. Lendol L. Davis, Killeen Women's Health Center, Mr. Sherwood C. Lynn, Jr., Nova Health Systems, Ms. Pamela J. Richter and Whole Woman's Health on 09/02/2015. Supreme Court Number: 15-274. [14-50928] (CAV)

11/19/2015 SUPREME COURT ORDER received granting petition for writ of certiorari filed by Appellees Cross-Appellants Whole Woman's Health, Ms. Pamela J. Richter, Austin Women's Health Center, Killeen Women's Health Center, Nova Health Systems, Mr. Sherwood C. Lynn, Jr. and Mr. Lendol L. Davis in 1450928 on 11/13/2015. [8062769-1] [14-50928] (LGL)

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH; ABORTION ADVANTAGE; AUSTIN WOMEN'S HEALTH CENTER; KILLEEN WOMEN'S HEALTH CENTER; NOVA HEALTH SYSTEMS d/b/a REPRODUCTIVE SERVICES; SHERWOOD C. LYNN, JR., M.D.; PAMELA J. RICHTER, D.O.; LENDOL L. DAVIS, M.D.; and LAMAR ROBINSON, M.D., on behalf of themselves and their patients,	CIVIL ACTION
Plaintiffs,	CASE NO. A14CV0284 LY
v.	
DAVID LAKEY, M.D., Commissioner of the Texas Department of State Health Services; MARI ROBINSON, Executive Director of the Texas Medical Board; DAVID ESCAMILLA, County Attorney for Travis County; JAIME ESPARZA, District Attorney for El Paso County; RENÉ GUERRA, Criminal District Attorney for Hidalgo County; JAMES E. NICHOLS, County Attorney for Bell County; SUSAN D. REED, Criminal	

District Attorney for Bexar County; JOE SHANNON, JR., Criminal District Attorney for Tarrant County; CRAIG WATKINS, Criminal District Attorney for Dallas County, in their official capacities,

Defendants.

COMPLAINT

(Filed Apr. 2, 2014)

Plaintiffs, by and through their undersigned attorneys, bring this complaint against the above-named Defendants, their employees, agents, and successors in office, and in support thereof allege the following:

I. PRELIMINARY STATEMENT

1. Pursuant to 42 U.S.C. § 1983, Plaintiffs, who are Texas health care providers, bring this action on behalf of themselves and their patients. They seek declaratory and injunctive relief from certain unconstitutional requirements imposed by Texas House Bill No. 2 ("the Act"), Act of July 18, 2013, 83rd Leg., 2nd C.S., ch. 1, Tex. Gen. Laws, and its implementing regulations, *see* 38 Tex. Reg. 6536-46 (Sept. 27, 2013)

(notice of proposed rules); 38 Tex. Reg. 9577-93 (adoption of proposed rules).[1]

2. The Act targets abortion providers for the imposition of unique regulatory burdens that are not imposed on any other health care providers in Texas, are inconsistent with accepted medical standards, impose costs that are far in excess of any potential benefits, and will dramatically reduce the number and geographic distribution of medical facilities in the State where women can access safe and legal abortion services.

3. These regulatory burdens include the "admitting privileges requirement," which provides, in relevant part, that "[a] physician performing or inducing an abortion must, on the date the abortion is performed or induced, have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced." Act, § 2 (codified at Tex. Health & Safety Code Ann § 171.0031); 25 Tex. Admin Code §§139.53(c), 139.56(a).

4. They also include the "ASC requirement," which provides, in relevant part, that "the minimum standards for an abortion facility must be equivalent to the minimum standards adopted under [Texas Health & Safety Code] Section 243.010 for ambulatory

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[1] A copy of the Act is attached hereto as Exhibit 1. The pages of the Texas Register providing notice of the proposed regulations and their adoption are attached hereto as Exhibit 2.

surgical centers." Act, § 4 (codified at Tex. Health & Safety Code Ann. § 245.010(a)); 25 Tex. Admin. Code § 139.40.

5. The Act was signed by Governor Rick Perry on July 18, 2013.

6. Initially scheduled to take effect on October 29, 2013, the admitting privileges requirement was the subject of a pre-enforcement, facial challenge by a coalition of abortion providers, including some of the Plaintiffs in this case. It was permanently enjoined by a judge of this Court on October 28, 2013, Planned *Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 951 F. Supp. 2d 891, 909 (W.D. Tex. 2013), but the U.S. Court of Appeals for the Fifth Circuit stayed that injunction on the evening of October 31, 2013, 734 F.3d 406, 419 (5th Cir. 2013), *motion to vacate denied*, 134 S. Ct. 506 (2013), and ultimately reversed the district court's judgment, ___ F.3d ___, 13-51008, 2014 WL 1257965 (5th Cir. Mar. 27, 2014). The Fifth Circuit expressly noted that "[l]ater as-applied challenges" could be brought to "deal with subsequent, concrete constitutional issues." *Id.* at * 2.

7. Here, Plaintiffs Whole Woman's Health and Dr. Lynn challenge the admitting privileges requirement as applied to the licensed abortion facility operated by Whole Woman's Health in McAllen (the "McAllen clinic"). The McAllen clinic is currently the only licensed abortion facility in the Rio Grande Valley. During the past ten years, over 14,000 abortions were performed at the McAllen clinic; only two

of those patients needed to be transported from the clinic to a hospital. The McAllen clinic has not been able to provide abortion services since the admitting privileges requirement took effect.

8. Plaintiffs Nova Health Systems d/b/a Reproductive Services ("Reproductive Services") and Dr. Richter challenge the admitting privileges requirement as applied to the licensed abortion facility operated by Reproductive Services in El Paso (the "El Paso clinic"). The El Paso clinic is currently one of only two licensed abortion facilities located west of San Antonio. During the past ten years, over 17,000 abortions were performed at the El Paso clinic; not one of those patients needed to be transported from the clinic to a hospital. Absent injunctive relief from the admitting privileges requirement, the El Paso clinic will be forced to cease providing abortion services after May 13, 2014, when Dr. Richter's temporary admitting privileges at an El Paso-area hospital are set to expire.

9. The ASC requirement is scheduled to take effect on September 1, 2014. *See* Act, § 4 (codified at Tex. Health & Safety Code Ann. § 245.010(a)).

10. All plaintiffs challenge the ASC requirement on its face.

11. In addition, Whole Woman's Health and Dr. Lynn challenge the ASC requirement as applied to the McAllen clinic, and Reproductive Services and Dr. Richter challenge the ASC requirement as applied to the El Paso clinic.

12. Prior to the passage of the Act, there were over three dozen licensed abortion clinics in Texas. Since the admitting privileges requirement has taken effect, that number has dropped significantly. If the ASC requirement is permitted to take effect, there will be fewer than ten abortion clinics in the State, all clustered in eastern metropolitan areas, with no clinics west or south of San Antonio.

II. JURISDICTION AND VENUE

13. Jurisdiction is conferred on this Court by 28 U.S.C. §§ 1331 and 1343(a)(3).

14. Plaintiffs' claims for declaratory and injunctive relief are authorized by 28 U.S.C. §§ 2201 and 2202, by Rules 57 and 65 of the Federal Rules of Civil Procedure, and by the general legal and equitable powers of this Court.

15. Venue is appropriate under 28 U.S.C. § 1391(b)(1) because some Defendants reside in this district.

III. PLAINTIFFS

16. Plaintiff Whole Woman's Health operates licensed abortion facilities in Austin, Fort Worth, and San Antonio. In addition, it operates a licensed ASC in San Antonio. These medical facilities have provided high quality reproductive health care services, including abortion services, to Texas women for over a decade. Until the admitting privileges requirement

took effect, Whole Woman's Health also operated licensed abortion facilities in Beaumont and McAllen. If the admitting privileges requirement were enjoined with respect to the McAllen clinic, Whole Woman's Health would immediately resume providing services at that location. Whole Woman's Health sues on behalf of itself and its patients.

17. Plaintiff Sherwood C. Lynn, Jr., M.D., is a board-certified obstetrician-gynecologist ("ob-gyn") licensed to practice medicine in the State of Texas. He has over 35 years of experience providing reproductive health care, including abortion care. He serves as the Medical Director of Whole Woman's Health's licensed abortion facility and ASC in San Antonio, and he seeks to provide abortion services at the McAllen clinic. Although he has admitting privileges at a hospital in San Antonio, no hospital within 30 miles of the McAllen clinic will grant him admitting privileges. Dr. Lynn sues on behalf of himself and his patients.

18. Plaintiff Abortion Advantage operates a licensed abortion facility in Dallas. It has provided high quality reproductive health care services, including abortion services, to Texas women for over 25 years. Abortion Advantage sues on behalf of itself and its patients.

19. Plaintiff Lamar Robinson, M.D., is an ob-gyn licensed to practice medicine in the State of Texas. He has over 28 years of experience providing reproductive health care, including abortion care. He

currently serves as the Medical Director of Abortion Advantage. Dr. Robinson sues on behalf of himself and his patients.

20. Plaintiffs Austin Women's Health Center and Killeen Women's Health Center (collectively, the "Health Centers") operate licensed abortion facilities in Austin and Killeen, respectively. These medical facilities have provided high quality reproductive health care services, including abortion services, to Texas women for over 35 years. The Health Centers sue on behalf of themselves and their patients.

21. Plaintiff Lendol L. "Tad" Davis, M.D., is a board-certified ob-gyn licensed to practice medicine in the State of Texas. He has over 35 years of experience providing reproductive health care, including abortion care. He serves as the Medical Director of Austin Women's Health Center and Killeen Women's Health Center. Dr. Davis sues on behalf of himself and his patients.

22. Plaintiff Nova Health Systems d/b/a Reproductive Services ("Reproductive Services") operates a licensed abortion facility in El Paso. The El Paso clinic has provided high-quality reproductive health care services, including abortion services, to Texas women for over 35 years. If the admitting privileges requirement is not enjoined prior to May 14, 2014, then the El Paso clinic will be forced to close on that date. Reproductive Services sues on behalf of itself and its patients.

23. Plaintiff Pamela J. Richter, D.O., is a board-eligible family medicine doctor licensed to practice medicine in the State of Texas. She has been providing reproductive health care, including abortion care, for over 20 years. She currently serves as Medical Director of the El Paso clinic. Dr. Richter has temporary admitting privileges at Foundation Surgical Hospital of El Paso, which will expire on May 13, 2014. No hospital within 30 miles of the El Paso clinic will grant Dr. Richter admitting privileges that are effective after May 13, 2014. She sues on behalf of herself and her patients.

IV. DEFENDANTS

24. Defendant David Lakey, M.D., is the Commissioner of the Texas Department of State Health Services ("the Department" or "DSHS"). The Department is generally charged with enforcement of the provisions of the Act challenged here. Commissioner Lakey is sued in his official capacity and may be served with process at 1100 West 49th Street, Austin, Texas 78756-3199.

25. Defendant Mari Robinson is the Executive Director of the Texas Medical Board ("the Board"). The Board is empowered to undertake disciplinary proceedings against a physician who violates certain requirements of the Act. Ms. Robinson is sued in her official capacity and may be served with process at 333 Guadalupe, Tower 3, Suite 610, Austin, Texas 78701.

26. Defendant David Escamilla is the County Attorney for Travis County. He is responsible for prosecuting misdemeanors, including criminal violations of the Act, occurring in Travis County. He is sued in his official capacity and may be served with process at 314 West 11th Street, Room 300, Austin, Texas 78701.

27. Defendant Jaime Esparza is the District Attorney for El Paso County. He is responsible for prosecuting misdemeanors, including criminal violations of the Act, occurring in El Paso County. He is sued in his official capacity and may be served with process at El Paso County Courthouse, 500 East San Antonio Avenue, Room 201, El Paso, Texas 79901-2419.

28. Defendant René Guerra is the Criminal District Attorney for Hidalgo County. He is responsible for prosecuting misdemeanors, including criminal violations of the Act, occurring in Hidalgo County. He is sued in his official capacity and may be served with process at 100 North Closner Blvd., Room 303, Edinburg, Texas 78539-3563.

29. Defendant James E. Nichols is the County Attorney for Bell County. He is responsible for prosecuting misdemeanors, including criminal violations of the Act, occurring in Bell County. He is sued in his official capacity and may be served with process at the Bell County Justice Center, 1201 Huey Road, Belton, Texas 76513.

30. Defendant Susan D. Reed is the Criminal District Attorney for Bexar County. She is responsible for prosecuting misdemeanors, including criminal violations of the Act, occurring in Bexar County. She is sued in her official capacity and may be served with process at 101 West Nueva Street, 4th Floor, San Antonio, Texas 78205-3406.

31. Defendant Joe Shannon, Jr. is the Criminal District Attorney for Tarrant County. He is responsible for prosecuting misdemeanors, including criminal violations of the Act, occurring in Tarrant County. He is sued in his official capacity and may be served with process at the Tim Curry Criminal Justice Center, 401 West Belknap Street, Fort Worth, Texas 76196-0201.

32. Defendant Craig Watkins is the Criminal District Attorney for Dallas County. He is responsible for prosecuting misdemeanors, including criminal violations of the Act, occurring in Dallas County. He is sued in his official capacity and may be served with process at 133 North Riverfront Boulevard, LB 19, Dallas, Texas 75207.

V. FACTUAL ALLEGATIONS

A. The Admitting Privileges Requirement

Overview

33. The admitting privileges requirement provides, inter alia, that "[a] physician performing or inducing an abortion must, on the date the abortion is

performed or induced, have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced." Act, § 2 (codified at Tex. Health & Safety Code Ann. § 171.0031); 25 Tex. Admin. Code §§ 139.53(c), 139.56(a).

34. Any physician who violates this requirement commits a Class A misdemeanor offense. The physician is also subject to license revocation, and the abortion facility at which the abortion is performed is subject to license revocation. *See* Tex. Health & Safety Code § 171.0031; Tex. Occ. Code § 164.055(a); 25 Tex. Admin. Code § 139.32.

35. Prior to the enactment of the admitting privileges requirement, Texas law required that: "A licensed abortion facility shall have a readily accessible written protocol for managing medical emergencies and the transfer of patients requiring further emergency care to a hospital. The facility shall ensure that the physicians who practice at the facility have admitting privileges or have a working arrangement with a physician(s) who has admitting privileges at a local hospital in order to ensure the necessary back up for medical complications." 25 Tex. Admin. Code § 139.56(a) (2012).

36. This regulation had been in effect since 2009 and had never been challenged in litigation.

37. Both the McAllen clinic and the El Paso clinic were in compliance with this regulation when the admitting privileges requirement was enacted.

38. Both the McAllen clinic and the El Paso clinic continue to have a readily accessible written protocol for managing medical emergencies and the transfer of patients requiring further emergency care to a hospital.

39. Both the McAllen clinic and the El Paso clinic continue to ensure that the physicians who practice at the respective facilities have a working arrangement with at least one physician who has admitting privileges at a local hospital.

40. The admitting privileges requirement effectively gives local hospitals veto power over the McAllen clinic's ability to provide abortion care to women in the Rio Grande Valley and the El Paso clinic's ability to provide abortion care to women in West Texas. Hospitals in Texas have broad discretion to set the criteria for granting admitting privileges and can thereby grant or refuse privileges on the basis of idiosyncratic rules and regulations. *See* Tex. Health & Safety Code § 241.101.

41. Hospitals within Texas have varying requirements for admitting privileges. Some require a certain number of patient admissions each year; some require physicians to reside within a certain distance from the hospital; others limit admitting privileges to physicians who are directly employed by or under contract with the hospital; while others require a physician to designate an alternate physician with admitting privileges at the hospital who is willing to cosign the application. These criteria, unrelated to a

physician's ability to provide high-quality abortion care, may preclude physicians from obtaining admitting privileges at a local hospital.

The McAllen Clinic's Inability to Comply with the Admitting Privileges Requirement

42. After the admitting privileges requirement was enacted, four physicians affiliated with Whole Woman's Health, including Dr. Lynn, sought to obtain admitting privileges at a hospital within 30 miles of the McAllen clinic. Each physician is a board-certified ob-gyn and experienced abortion provider, and three of the four have admitting privileges at hospitals in other parts of the State.

43. None was able to obtain admitting privileges at a hospital within 30 miles of the McAllen clinic.

44. There are eight hospitals located within 30 miles of the McAllen clinic. Each of them requires, as a condition of granting admitting privileges, that an application be signed by a "designated alternate" physician willing to attend to the applicant's patients when the applicant is unavailable. The designated alternate physician must already have admitting privileges at the hospital. If an application is not signed by a designated alternate physician, it will not be considered, regardless of whether the applicant meets the hospital's other requirements.

45. Only one eligible physician was willing to serve as a designated alternate physician for the

physicians affiliated with the McAllen clinic, and this physician only has privileges at one area hospital: Doctors Hospital at Renaissance. The other physicians approached by the clinic expressed concern about retaliation from the hospitals at which they had admitting privileges and the possibility that their privileges would be revoked or discontinued if they facilitated the application of a known abortion provider.

46. Thus, the physicians affiliated with the McAllen clinic were only able to satisfy the application criteria for Doctors Hospital at Renaissance. At this hospital, the first step in applying for admitting privileges is to submit a written request for an application.

47. In September 2013, all four physicians submitted such requests.

48. In November or December 2013, each of the physicians received a letter in response stating that, based on the recommendation of the hospital's Credentials Committee, the Medical Executive Committee was denying the physician's request for an application for privileges. Each letter further stated that the Board of Governors had considered the request and determined not to extend an application "as authorized under the Bylaws and Rules and Regulations of the Medical Staff for the Hospital" and that the "decision of the Governing Body was not based on clinical competence consideration." The letters provided no other explanation as to why each of the four

physicians was denied the opportunity to apply for admitting privileges at the hospital.

49. Whole Woman's Health has been unable to recruit a physician with admitting privileges at a hospital within 30 miles of the McAllen clinic to provide abortion services at the clinic.

Challenges Facing Women in the Rio Grande Valley Who Seek Abortion Care

50. In 2010, the latest year for which DSHS data is available, 2,845 women from the Rio Grande Valley had abortions in Texas. *See* Texas Dep't of State Health Servs., Table 35: Induced Terminations of Pregnancy by County of Residence and Race/ Ethnicity, http://www.dshs.state.tx.us/chs/vstat/vs10/t35.shtm (last accessed April 1, 2014).

51. The McAllen clinic is currently the only licensed abortion facility in the Rio Grande Valley.

52. Absent as-applied relief from the Court, the McAllen clinic will be unable to resume its provision of medical services, leaving women in the Rio Grande Valley without an abortion provider in their region. The closest abortion provider would be in Corpus Christi, which is over 150 miles from McAllen.

53. For many women in the Rio Grande Valley, a 150-mile distance is a substantial obstacle to accessing abortion care.

54. The Rio Grande Valley is comprised of four counties along the eastern border of Texas and Mexico: Starr County, Hidalgo County, Willacy County, and Cameron County. It has a population of approximately 1.3 million.[2]

55. There are some urban centers in the Rio Grande Valley—for example, in McAllen, Harlingen, and Brownsville—but much of the region is rural. The rural areas include unincorporated towns known as *colonias*, which are more prevalent in the Rio Grande Valley than anywhere else in the United States. *Colonias* can be hard to reach because they often do not appear on maps. In many *colonias*, residents have a difficult time accessing basic public services, including water, electricity, sewage and drainage systems and paved roads. *See* Federal Reserve Bank of Dallas, *Texas Colonias: A Thumbnail Sketch of the Conditions, Issues, Challenges and Opportunities* (2007), http://www.dallasfed.org/assets/documents/cd/pubs/ colonias.pdf.

56. The vast majority of people living in the Rio Grande Valley are Latino.[3] Latinos in Texas are three

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[2] U.S. Census Bureau, Population Div., Annual Estimates of the Resident Population: Apr. 1, 2010 to July 1, 2012 (2010), http://factfinder2.census.gov/bkmk/table/1.0/en/PEP/2012/PEPANNRES/0500000US48061105000000US4821510500000US4842710500000US48489 (last accessed April 1, 2014).

[3] U.S. Census Bureau, Population Div., ACS Demographic and Housing Estimates, 2009-2011 (2007-2011), http://factfinder2.census.gov/bkmk/table/1.0/en/ACS/11.5YR/DP05/0500000US4806110

(Continued on following page)

times as likely to live in poverty as white people.[4] Overall, approximately one-third of the population in the Rio Grande Valley lives in poverty.[5]

57. Nearly half of the population has less than a ninth-grade education,[6] and the region has a high proportion of farmworkers and seasonal migrant workers. Employment outside of the agricultural field, especially for uneducated and unskilled workers, is scarce. As a result, unemployment in the Rio Grande Valley is higher than in the rest of the State.[7]

500000US4821510500000US4842710500000US48489 (last accessed April 1, 2014).

[4] KFF, Poverty Rate by Race/Ethnicity (2010-2011), http://kff.org/other/state-indicator/povertyrate-by-raceethnicity/ (last accessed April 1, 2014).

[5] U.S. Census Bureau, Poverty Status in the Past 12 Months (2009-2011), http://factfinder2. census. gov/bkmk/table/1.Wen/ACS/11.3YR/S1701/0500000115480611050000US4821510500000US4842710500000US48489 (last accessed April 1, 2014).

[6] U.S. Census Bureau, Educational Attainment—2009-2011 American Community Survey 3-year Estimates, 2009—2011 (2009-2011), http://factfinder2.census.gov/bkmk/table/1.0/en/ACS/113YR/S1501/0500000115480611050000US4821510500000US4842710500000US48489 (last accessed April 1, 2014).

[7] U.S. Census Bureau, Employment Status—2009-2011 American Community Survey 3-Year Estimates, 2009-2011 (2009-2011), http://factfinder2.census.gov/bkmk/tabl e/1.0/en/ACS/11.5YR/S2301/0400000US4810500000US4806110500000US4821510500000US484271 0500000US48489 (last accessed April 1, 2014).

58. Most of the Rio Grande Valley is designated as a medically underserved area by the federal government because the population has a shortage of health services and faces numerous socioeconomic barriers to health care access. *See* Texas Dep't of State Health Servs., *MUA and MUP Designations*, http://www.dshs.state.tx.us/CHS/hprc/MUAlist.shtm (last updated April 10, 2012).

59. Women living in the Rio Grande Valley face many challenges in accessing reproductive health care services generally and abortion care specifically. These challenges include poverty, lack of service providers, lack of access to transportation, need for childcare, and inability to take time off from work.

60. Many women in the Rio Grande Valley rely on State-subsidized health clinics for preventative reproductive health care, such as pap smears and contraceptives. In 2011, the number of these clinics was dramatically reduced as a result of changes in State law. Few of them remain in the Rio Grande Valley, and demand for their services now exceeds their capacity. As a result, women must endure long waits for appointments, and some simply live too far from the nearest clinic to access services. The reduction in State-subsidized clinics has had a devastating impact on women's ability to access preventative reproductive health care.

61. As a result, it is now much harder for women in the Rio Grande Valley to avoid unwanted pregnancies. Many women do not want to have additional

children, but they no longer have access to affordable contraceptives and cannot afford the cost of a sterilization procedure. *See* Center for Reproductive Rights & National Latina Institute for Reproductive Health, *Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley* (2013), available at http://www.nuestrotexas.org/pdf/NT-spread.pdf (last accessed April 1, 2014).

62. The obstacles preventing women in the Rio Grande Valley from accessing preventative services at non-local clinics will likewise prevent women from accessing abortion services at non-local clinics.

63. As a result, women in the Rio Grande Valley are left with few options for controlling the number and spacing of their children.

The El Paso Clinic's Inability to Comply with the Admitting Privileges Requirement after May 13, 2014

64. After the admitting privileges requirement was enacted, Dr. Richter sought to obtain admitting privileges at a hospital within 30 miles of the El Paso Clinic. She is the Medical Director of the clinic and the only physician who provides abortion services there.

65. In addition to her work at the El Paso clinic, Dr. Richter also works for the State of Texas. She serves as a staff physician at the state supported living center ("State Center") in El Paso operated by

the Texas Department of Aging and Disability Services ("DADS"). The State Center provides 24-hour residential services, comprehensive behavioral treatment services, vocational and rehabilitation services, and general health care services to people with intellectual and developmental disabilities.

66. Previously, from 1990 to 2001, Dr. Richter maintained a family medicine practice in El Paso.

67. From January 1990 to May 2003, Dr. Richter had admitting privileges at Del Sol Medical Center, which is located within 30 miles of the El Paso clinic. One of the criteria for maintaining admitting privileges at that hospital is admitting a minimum number of patients to the hospital each year. After Dr. Richter closed her private practice in 2001, she was no longer able to admit the requisite number of patients to the hospital. As a result, when her privileges came up for renewal in 2003, they were not renewed.

68. Subsequent to the enactment of the admitting privileges requirement, one hospital within 30 miles of the El Paso clinic granted Dr. Richter temporary admitting privileges, effective through May 13, 2014. To date, no hospital within 30 miles of the El Paso clinic has been willing to grant Dr. Richter admitting privileges that are effective after May 13, 2014.

69. Reproductive Services has been unable to recruit a physician with admitting privileges at a

hospital within 30 miles of the El Paso clinic to provide abortion services at the clinic.

Challenges Facing Women in West Texas Who Seek Abortion Care

70. Currently, the El Paso clinic is one of only two licensed abortion facilities west of San Antonio.

71. Absent as-applied relief from the Court, the El Paso clinic will be forced to stop providing abortion services after May 13, 2014, leaving a huge region of the State with only a single abortion provider. Women unable to get an appointment with that provider would have to travel to San Antonio to obtain abortion services. San Antonio is over 550 miles from El Paso.

72. For many women in West Texas, a 550-mile distance is a substantial obstacle to accessing abortion care.

73. West Texas is a vast region with numerous, largely rural, counties.

74. The "Trans-Pecos" region of West Texas is comprised of nine counties: Brewster, Culberson, El Paso, Hudspeth, Jeff Davis, Pecos, Presidio, Reeves, and Terrell. Approximately 877,000 people live in these counties, and over 80% of them are Latino. The region has high levels of poverty: 24% of the population as a whole, and 27% of the Latino population, live below the poverty line. Nearly one-third of the population has a household income less than $25,000

a year. *See* Institute for Demographic and Socioeconomic Research, TxDOT Data Analysis Tool, at http://idserportal.utsa.edu/txDoT/OneStop/Output.aspx?id=8137&tp=single&1=11 (aggregate data for Brewster, Culberson, El Paso, Hudspeth, Jeff Davis, Pecos, Presidio, Reeves, and Terrell counties) (last accessed April 1, 2014).

75. Most of the Trans-Pecos region is designated as a medically underserved area by the federal government. *See* Texas Dep't of State Health Servs., *MUA and MUP Designations*, http://www.dshs.state.tx.us/CHS/hprc/MUAlist.shtm (last updated April 10, 2012).

76. In 2010, the latest year for which DSHS data is available, 2,278 women in the Trans-Pecos region had abortions in Texas; 2,216 of them were from El Paso County. *See* Texas Dep't of State Health Servs., Table 35: Induced Terminations of Pregnancy by County of Residence and Race/Ethnicity, http://www.dshs.state.tx.us/chs/vstat/vs10/t35.shtm (last accessed April 1, 2014).

77. If the El Paso clinic closes, the other licensed abortion facility in the region would not be able to meet patient demand for services. As a result, some women would have to endure long waits for an appointment, and other women would be turned away.

Safety of Abortion Care at the McAllen and El Paso Clinics

78. As applied to the McAllen and El Paso clinics, the admitting privileges requirement does not advance the State's interest in women's health.

79. There are generally two methods of performing abortions in the United States: surgical abortion, which involves the use of medical instruments to evacuate the contents of the uterus; and medical abortion, which involves the administration of medications that cause the termination of a pregnancy.

80. Both types of abortion are extremely safe. The mortality rate from use of penicillin is roughly three times higher than the mortality rate from abortion, and the mortality rate from childbirth is roughly 14 times higher. Serious complications from abortion are rare and hardly ever require hospitalization.

81. The types of abortions performed at the McAllen and El Paso clinics are among the safest of all abortion procedures.

82. While abortion is extremely safe throughout pregnancy, a woman's risk of experiencing an abortion-related complication increases with the gestational age of her pregnancy. Therefore, earlier abortions have less risk of complications.

83. The McAllen clinic provided abortion services prior to 16 weeks of pregnancy. The highest

level of sedation offered to patients at the McAllen clinic was moderate sedation/analgesia, also known as conscious sedation.

84. The El Paso clinic provides abortion services prior to 16 weeks of pregnancy. The highest level of sedation offered to patients at the El Paso clinic is minimal sedation/analgesia.

85. During the past ten years, the McAllen clinic only had to transfer two patients from the clinic to a hospital. Over 14,000 abortions were performed there during that period.

86. During the past ten years, the El Paso clinic has not had to transfer any patients from the clinic to the hospital. Over 17,000 abortions were performed there during that period.

Accepted Medical Standards for Outpatient Practice

87. The admitting privileges requirement is inconsistent with accepted medical standards.

88. In Texas, physicians and other licensed medical practitioners provide a variety of surgical and non-surgical procedures in outpatient settings, some of which are comparable in safety to abortion and some of which entail far greater risks than abortion. Yet only physicians providing abortion services are required to have admitting privileges at a local hospital.

89. Moreover, Texas law does not require any type of medical facility besides abortion clinics to employ physicians with admitting privileges as a condition of licensure. The regulations governing freestanding emergency medical care facilities and end stage renal disease facilities require only that a facility have a transfer agreement with a hospital. *See* 25 Tex. Admin. Code §§ 131.52(s), 131.66, 131.67 (freestanding emergency medical care facilities); 25 Tex. Admin Code § 117.45(b)(4) (end stage renal disease facilities). The regulations governing ambulatory surgical centers ("ASCs") permit a facility to maintain a transfer agreement with a hospital as an alternative to employing physicians with admitting privileges. *See* 25 Tex. Admin. Code § 135.4(c)(11)(B). And, the regulations governing birthing centers and special care facilities for the treatment of terminally ill patients require only that a facility has a plan for managing patient emergencies. *See* 25 Tex. Admin. Code § 137.46 (birthing centers); 25 Tex. Admin. Code § 125.32(a)(3) (special care facilities).

90. Moreover, the nation's leading medical associations and accreditation bodies—including the American Medical Association ("AMA"), the American College of Obstetricians and Gynecologists ("ACOG"), the American College of Surgeons ("ACS"), the American Society of Anesthesiologists ("ASA"), the Accreditation Association for Ambulatory Health Care ("AAAHC"), the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF"), and the Joint Commission (formerly the Joint Commission on

Accreditation of Healthcare Organizations or "JCAHO")—recognize that admitting privileges at a local hospital are not required for the safe performance of outpatient procedures.

91. In connection with the facial challenge to the admitting privileges requirement, the AMA and ACOG filed a brief in the Fifth Circuit explaining that admitting privileges at a local hospital are not required for the safe performance of abortion procedures in outpatient settings and are not part of the standard of care. *See* Br. of *Amicus Curiae* Am. Coll. of Obstetricians & Gynecologists and Am. Med. Ass'n, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, ___ F.3d ___ (5th Cir. Mar. 27, 2014) (No. 13-51008), 2013 WL 6837500.

92. ACOG, ACS, and ASA have all issued guidelines concerning outpatient surgery. None requires that physicians performing outpatient surgery have admitting privileges at a local hospital.

93. The National Abortion Federation ("NAF") Clinical Policy Guidelines do not require physicians performing or supervising abortions to have admitting privileges at a local hospital.

94. Of the three major national organizations that accredit healthcare facilities—AAAHC, AAAASH, and the Joint Commission—none requires an outpatient facility to employ physicians with admitting privileges as a condition of accreditation.

95. In the rare event that a patient who has had an abortion requires hospitalization, the quality of care that she receives at the hospital will not be affected by whether her abortion provider has admitting privileges there. Upon the patient's arrival at the hospital via ambulance, an emergency room physician will evaluate the patient and consult with other specialists at the hospital as needed. The patient may require admission to the hospital, or she may simply be treated in the emergency room and then released. Either way, continuity of care can be maintained by direct telephone communication between the abortion provider and the emergency room physician, regardless of whether the abortion provider has admitting privileges at the hospital.

96. Physicians practicing in outpatient settings often refer patients for treatment at hospitals at which they do not have admitting privileges. This is standard medical practice.

97. In fact, the trend in medicine is toward bifurcation of outpatient practice and hospital-based practice, such that physicians are increasingly specializing in one type of practice setting or the other. Coordination and continuity of care of a patient that is transferred from an outpatient setting to a hospital are achieved through communication between the physician referring the patient to the hospital and the physician treating the patient at the hospital.

Futility of the Admitting Privileges Requirement As Applied to the McAllen and El Paso Clinics

98. Many complications from abortion arise only after a patient has left the clinic and returned home. This is almost always true of complications arising from medical abortions because the medications used to induce those abortions take time to exert their effects.

99. If a patient experiences a serious complication after she has left the clinic and returned home, the appropriate course of action would be for her to go to the nearest emergency room.

100. By forcing the McAllen and El Paso clinics to close, the admitting privileges requirement would require all women in the Rio Grande Valley and many women in West Texas to travel hundreds of miles from their homes to access abortion services, guaranteeing that each of those women would be hundreds of miles from the facility at which her abortion was performed if she experienced a serious complication after she returned home. Thus, the admitting privileges requirement does not make it more likely that women from the Rio Grande Valley or West Texas who experience abortion-related complications would be treated at a hospital where their abortion-provider has admitting privileges.

101. As applied to the McAllen and El Paso clinics, the admitting privileges requirement is therefore futile.

Harms to Women in the Rio Grande Valley and West Texas Caused by the Admitting Privileges Requirement

102. By sharply restricting their access to safe and legal abortion services, the admitting privileges requirement puts the health of women in the Rio Grande Valley and West Texas at risk.

103. As a result of the admitting privileges requirement, some women will be delayed in accessing abortion care, some will be forced to carry an unwanted pregnancy to term, and some will attempt to self-induce abortion. Each of these courses of action is riskier than having an abortion at the McAllen or El Paso clinic without delay.

104. Although abortion is very safe throughout pregnancy, the risks of experiencing an abortion-related complication increase with gestational age. As a result, women who are delayed in accessing abortion services are subject to greater health risks than women who are not delayed.

105. Women who are unable to obtain abortion services must instead carry their pregnancies to term and give birth. These women are also subject to increased health risks because the risk of death from childbirth is 14 times higher than the risk of death from abortion.

106. Additionally, some women who cannot access legal abortion services will instead attempt self-induction of abortion. Prior to the enactment of

the admitting privileges requirement, self-abortion was already practiced by women in the Rio Grande Valley and West Texas who were desperate to end a pregnancy but did not have the means to obtain abortion services at a licensed clinic.

107. During the four-month period of time when the McAllen clinic was open but not providing abortion services, clinic staff members encountered a larger number of prospective patients who had attempted self-abortion. These women utilized a variety of methods, including herbal teas, douches, physical trauma to the abdomen, and medications purchased on the black market.

108. Many women are aware that misoprostol can be used to induce an abortion. This medication is available over-the-counter in Mexico and is widely trafficked in the Rio Grande Valley and West Texas, which both border Mexico. It is also sold on the internet.

109. Like any medication obtained on the black market, misoprostol obtained in this way can be counterfeit, inappropriate for a particular woman's medical needs, or used incorrectly because a woman does not have adequate information.

110. Self-induction of abortion is less safe than abortion performed by a trained medical practitioner.

111. In addition to abortion services, the McAllen clinic provided other gynecological and family planning services, such as diagnosis and

treatment of sexually transmitted infections, contraceptive counseling and provision, pregnancy testing, and diagnosis and treatment of abnormal pap smears. The McAllen clinic also provided assistance, including counseling and referrals, to pregnant women interested in adoption.

112. Without the revenue generated from providing abortion services, the McAllen clinic was unable to sustain the remainder of its practice after the admitting privileges requirement took effect. As a result, it is no longer able to provide these other services to women in the Rio Grande Valley.

113. In addition to abortion services, the El Paso clinic provides other gynecological and family planning services, such as annual well-woman examinations, which include pelvic examinations, pap smears, and breast examinations; testing and treatment for STIs; provision of contraceptives; and pregnancy testing. The El Paso clinic also works with an affiliated adoption agency to help interested women place their children for adoption.

114. If the El Paso clinic is forced by the admitting privileges requirement to stop providing abortion services, it would have to close, and would therefore be unable to provide these other services to women in West Texas.

B. The ASC Requirement

115. The ASC requirement provides that "[o]n or after September 1, 2014, the minimum standards for an abortion facility must be equivalent to the minimum standards . . . for ambulatory surgical centers." Act, § 4 (codified at Tex. Health & Safety Code Ann. § 245.010(a)); 25 Tex. Admin. Code § 139.40.

116. Failure to comply with those standards may give rise to criminal, civil, and administrative penalties. Tex. Health & Safety Code Ann. §§ 245.014 (criminal penalties), 245.015 (civil penalties), 245.017 (administrative penalties). It may also result in the denial, suspension, probation, or revocation of an abortion facility license. Tex. Health & Safety Code Ann. § 245.012.

117. Independently of the Act, Texas law requires that lain abortion of a fetus age 16 weeks or more may be performed only at an ambulatory surgical center or hospital licensed to perform the abortion." Tex. Health & Safety Code Ann. §171.004. Plaintiffs do not challenge this requirement, which would remain in effect if the Act and its implementing regulations were enjoined.

118. The ASC requirement will force all licensed abortion facilities to meet detailed physical plant requirements, which specify, among other things, hallway widths; ceiling heights; area of various rooms; floor, wall, and ceiling finishes; HVAC system requirements; and number and configuration of

bathrooms, janitorial closets, and parking spaces. *See* 25 Tex. Admin. Code § 139.40 (incorporating by reference, *inter alia*, 25 Tex. Admin. Code § 135.52).

119. An ASC is far more expensive to acquire and operate than a health care facility that meets existing abortion facility standards.

120. The licensed abortion facilities operated by Whole Woman's Health in Austin, Fort Worth, and San Antonio do not meet the minimum standards for ASCs. Likewise, the McAllen clinic does not meet the minimum standards for ASCs.

121. The licensed abortion facility operated by Abortion Advantage does not meet the minimum standards for ASCs.

122. The licensed abortion facilities operated by the Health Centers do not meet the minimum standards for ASCs.

123. The El Paso clinic does not meet the minimum standards for ASCs.

124. If the ASC requirement is permitted to take effect, there would be fewer than ten facilities in the State that are permitted to provide abortion services ("abortion-care ASCs"). Those facilities would be clustered in eastern metropolitan areas. There would be no abortion-care ASCs west or south of San Antonio.

125. The closest abortion-care ASC to McAllen would be in San Antonio, over 235 miles away. The

closest abortion-care ASC to El Paso would also be in San Antonio, over 550 miles away.

126. Requiring licensed abortion facilities to meet the minimum standards for ASCs will not enhance the safety of abortion procedures. It will only reduce the availability of abortion services, and thereby threaten the health of women seeking abortion services.

127. Apart from abortion procedures, Texas law does not require any other outpatient surgical or medical procedures to be performed in an ASC.

128. Many procedures commonly performed in outpatient settings are comparable to surgical abortion in terms of risks, invasiveness, instrumentation, and duration. These include gynecological procedures such as dilation and curettage ("D&C") and non-gynecological procedures such as colonoscopy. Texas law does not require the facilities in which these procedures are performed to meet the minimum standards for ASCs.

129. Procedures that are more complex than abortion and entail greater risks of morbidity and mortality are also commonly performed in outpatient settings, including gynecological procedures such as laparoscopy and vaginal hysterectomy and non-gynecological procedures such as plastic surgery and bariatric surgery. These procedures are usually performed while the patient is under general anesthesia, which by itself is much riskier than abortion. Texas law does not require the facilities in which

these procedures are performed to meet the minimum standards for ASCs.

130. Moreover, Texas law does not require outpatient birthing centers to meet the minimum standards for ASCs. *See* Tex. Health & Safety Code Ann. § 244.010; 25 Tex. Admin Code §§ 137.1-137.55. But childbirth entails far more medical risks than abortion. As stated above, the risk of death from childbirth is approximately 14 times higher than the risk of death from abortion.

131. Certain characteristics of surgical abortion procedures render many of the minimum standards for ASCs inappropriate. For example, like other surgical procedures involving entry into the respiratory, alimentary, genital, or urinary tracts, surgical abortion procedures involve a clean-contaminated surgical site. Further, surgical abortion procedures do not entail an incision into the body; instead, they entail insertion of instruments into a body cavity through a natural orifice. In this respect, surgical abortion is analogous to insertion of a catheter.

132. Medical abortion does not involve surgery of any kind. As practiced in Texas, it entails the oral administration of medications—*i.e.*, the patient merely swallows a series of tablets.

133. The ASC requirement will not advance the State's interest in women's health.

134. The ASC requirement will not increase the safety of surgical abortion.

135. The ASC requirement will not increase the safety of medical abortion.

136. By reducing the number and geographic distribution of abortion providers in Texas, the ASC requirement will place substantial obstacles in the path of Texas women seeking abortion services and will expose those women to increased health risks.

137. These obstacles and risks will be greatest for women living in the Rio Grande Valley and West Texas.

CLAIMS FOR RELIEF

COUNT I

(Undue Burden/Admitting Privileges Requirement)

138. The allegations of paragraphs 1 through 137 are incorporated as though fully set forth herein.

139. As applied to the McAllen clinic, the admitting privileges requirement—standing alone and in conjunction with burdens imposed by other provisions of Texas law—imposes an undue burden on the right of women in the Rio Grande Valley to terminate a pregnancy prior to viability in violation of the Due Process Clause of the Fourteenth Amendment.

140. As applied to the El Paso clinic, the admitting privileges requirement—standing alone and in conjunction with burdens imposed by other provisions of Texas law—imposes an undue burden on the right

of women in West Texas to terminate a pregnancy prior to viability in violation of the Due Process Clause of the Fourteenth Amendment.

COUNT II

(Equal Protection/Admitting Privileges Requirement)

141. The allegations of paragraphs 1 through 140 are incorporated as though fully set forth herein.

142. As applied to the McAllen clinic, the admitting privileges requirement denies equal protection of the laws to Whole Woman's Health, Dr. Lynn, and their patients in the Rio Grande Valley in violation of the Equal Protection Clause of the Fourteenth Amendment.

143. As applied to the El Paso clinic, the admitting privileges requirement denies equal protection of the laws to Reproductive Services, Dr. Richter and their patients in West Texas in violation of the Equal Protection Clause of the Fourteenth Amendment.

COUNT III

(Unlawful Delegation/Admitting Privileges Requirement)

144. The allegations of paragraphs 1 through 143 are incorporated as though fully set forth herein.

145. The admitting privileges requirement improperly delegates lawmaking authority to hospitals

located within 30 miles of the McAllen clinic in violation of the Due Process Clause of the Fourteenth Amendment.

146. The admitting privileges requirement improperly delegates lawmaking authority to hospitals located within 30 miles of the El Paso clinic in violation of the Due Process Clause of the Fourteenth Amendment.

COUNT IV

(Arbitrary & Unreasonable State Action/Admitting Privileges Requirement)

147. The allegations of paragraphs 1 through 146 are incorporated as though fully set forth herein.

148. As applied to the McAllen clinic, the admitting privileges requirement constitutes arbitrary and unreasonable State action in violation of the Due Process Clause of the Fourteenth Amendment.

149. As applied to the provision of medical abortion at the McAllen clinic, the admitting privileges requirement constitutes arbitrary and unreasonable State action in violation of the Due Process Clause of the Fourteenth Amendment.

150. As applied to the El Paso clinic, the admitting privileges requirement constitutes arbitrary and unreasonable State action in violation of the Due Process Clause of the Fourteenth Amendment.

151. As applied to the provision of medical abortion at the El Paso clinic, the admitting privileges requirement constitutes arbitrary and unreasonable State action in violation of the Due Process Clause of the Fourteenth Amendment.

COUNT V

(Undue Burden/ASC Requirement)

152. The allegations of paragraphs 1 through 151 are incorporated as though fully set forth herein.

153. The ASC requirement—standing alone and in conjunction with burdens imposed by other provisions of Texas law—imposes an undue burden on the right of women in Texas to terminate a pregnancy prior to viability in violation of the Due Process Clause of the Fourteenth Amendment.

154. As applied to the McAllen clinic, the ASC requirement—standing alone and in conjunction with burdens imposed by other provisions of Texas law—imposes an undue burden on the right of women in the Rio Grande Valley to terminate a pregnancy prior to viability in violation of the Due Process Clause of the Fourteenth Amendment.

155. As applied to the El Paso clinic, the ASC requirement—standing alone and in conjunction with burdens imposed by other provisions of Texas law—imposes an undue burden on the right of women in West Texas to terminate a pregnancy prior to viability in violation of the Due Process Clause of the Fourteenth Amendment.

COUNT VI

(Equal Protection/ASC Requirement)

156. The allegations of paragraphs 1 through 155 are incorporated as though fully set forth herein.

157. The ASC requirement denies equal protection of the laws to Plaintiffs and their patients in violation of the Equal Protection Clause of the Fourteenth Amendment.

COUNT IV

(Arbitrary & Unreasonable State Action/ASC Requirement)

158. The allegations of paragraphs 1 through 157 are incorporated as though fully set forth herein.

159. The ASC requirement constitutes arbitrary and unreasonable State action in violation of the Due Process Clause of the Fourteenth Amendment.

160. As applied to the provision of medical abortion, the ASC requirement constitutes arbitrary and unreasonable State action in violation of the Due Process Clause of the Fourteenth Amendment.

REQUEST FOR RELIEF

Plaintiffs respectfully request that this Court:

A. Issue a declaratory judgment that the admitting privileges requirement is unconstitutional and unenforceable:

a. as applied to the McAllen clinic; and/or

b. as applied to the provision of medical abortion at the McAllen clinic; and/or

c. as applied to the El Paso clinic; and/or

d. as applied to the provision of medical abortion at the El Paso clinic; and/or

B. Issue a declaratory judgment that the ASC requirement is unconstitutional and unenforceable:

a. on its face; and/or

b. as applied to the provision of medical abortion; and/or

c. as applied to the McAllen clinic; and/or

d. as applied to the El Paso clinic; and/or

C. Permanently enjoin Defendants and their employees, agents, and successors in office from enforcing the admitting privileges requirement:

a. as applied to the McAllen clinic; and/or

b. as applied to the provision of medical abortion at the McAllen clinic; and/or

c. as applied to the El Paso Clinic; and/or

d. as applied to the provision of medical abortion at the El Paso clinic; and/or

D. Permanently enjoin Defendants and their employees, agents, and successors in office from enforcing the ASC requirement:

a. on its face; and/or

b. as applied to the provision of medical abortion; and/or

c. as applied to the McAllen clinic; and/or

d. as applied to the El Paso clinic; and/or

E. Grant Plaintiffs attorney's fees and costs pursuant to 42 U.S.C. § 1988; and/or

F. Grant such other and further relief as the Court may deem just, proper, and equitable.

Dated: April 2, 2014

Respectfully submitted,

/s/ Stephanie Toti [w/ permission]

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*Application for admission forthcoming

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

Whole Woman's Health, et al., Plaintiffs, v. **David Lakey, M.D.**, Commissioner of the Texas Department of State Health Services, et al., Defendants.	Civil Action No. 1:14-cv-284-LY

EMERGENCY MOTION OBJECTING TO MAGISTRATE'S ORDER ON MOTION TO COMPEL

(Filed Aug. 1, 2014)

Defendants David Lakey, Commissioner of the Texas Department of State Health Services, and Mari Robinson, Executive Director of the Texas Medical Board (collectively, Defendants) object to the Magistrate Judge's Order of July 31, 2014 (doc. 142), concerning Plaintiffs' Motion to Compel Disclosure of Written Communications between Vincent Rue and Defendants' Experts (doc. 115). Because the magistrate's order requires Defendants to produce privileged documents by 2:00 on Saturday, August 2, **Defendants request that the Court order an expedited response from Plaintiffs and rule by 4:00 today.**

I. Background

The Office of the Attorney General (OAG) retained Rue as a litigation consultant because of his ability to identify and prepare expert witnesses who are willing and qualified to defend the challenged abortion regulations. Rue was not retained for any expertise regarding the performance of abortions, hospital admitting privileges, or ambulatory surgical centers. In the course of his consulting duties, attorneys with OAG had privileged conversations with Rue regarding trial strategy and legal theories in order to determine which experts would be most useful in this case.

After identifying the experts, Rue also communicated with the experts on behalf of OAG regarding the preparation of the expert reports. Rue was privy to drafts of the expert reports and also conveyed details of the case to the State's experts. At OAG's direction, he assisted in the preparation of the expert reports by editing drafts or providing additional research to the experts as needed. Plaintiffs now seek discovery of all documents concerning communications between Rue and the State's testifying experts.

On July 24, 2014, Plaintiffs halted the deposition of James Anderson, a testifying expert for the State, and demanded a telephonic hearing on the State's assertion of privilege regarding conversations Anderson had with Rue. The matter was heard by Magistrate Judge Austin, who ordered Anderson to answer questions about oral communications that he had

with Rue. (doc. 114). Four days later, Plaintiffs filed a motion to compel production of all documents "concerning or reflecting communications" that Rue had with the State's testifying experts. (doc. 115). The matter was referred to Magistrate Judge Austin, who sua sponte set it for a hearing on the afternoon of July 31. (doc. 118)

Judge Austin then ordered that all communications between Rue and the State's testifying experts must be produced unless the communications were a mere "passing on" of a draft of the testifying expert's report between OAG and the testifying expert or a "passing on" between OAG and the testifying expert of the mental impressions, conclusions, opinions or legal theories of OAG. (doc. 142). To the extent the State believes any documents may be withheld under the "passing on" theory, the State must file a motion seeking permission to withhold those documents, produce a privilege log, and present the documents for *in camera* inspection by 2:00 on Saturday – despite the fact that trial is less than four days away and Plaintiffs have known for quite some time about Rue's involvement (but chose to do nothing about it until the week before trial). (doc. 142). Defendants object to the magistrate's order to the extent it requires Defendants to produce any documents concerning communications between Rue and the State's testifying experts. FED. R. CIV. P. 72(a).

II. ARGUMENT

A. Standard of Review

Rule 72(a) of the Federal Rules of Civil Procedure permits a party to submit objections to a magistrate judge's ruling on non-dispositive matters, such as discovery orders. FED. R. CIV. P. 72(a); 28 U.S.C. § 636(b)(1)(A). As a non-dispositive matter, the review of a magistrate's discovery order is governed by the "clearly erroneous or contrary to law" standard of review. *See Jesselson v. Outlet Assocs. of Williamsburg, Ltd. Partnership*, 784 F.Supp. 1223, 1228 (E.D.Va. 1991); *Tafas v. Dudas*, 530 F. Supp. 2d 786, 792 (E.D. Va. 2008). A court's "finding is 'clearly erroneous' when although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed." *United States v. United States Gypsum Co.*, 333 U.S. 364, 395, (1948); *see also Harman v. Levin*, 772 F.2d 1150, 1152 (4th Cir. 1985).

B. Communications Between Rue and the State's Testifying Experts Are Protected by the Work-Product Privilege.

The magistrate's order ignores what the Supreme Court has long recognized: attorneys use non-attorneys to help prepare for litigation, and documents prepared by non-attorneys are covered by work-product privilege. "[T]he [work-product] doctrine is an intensely practical one, grounded in the realities of litigation in our adversary system. One of those

realities is that attorneys often must rely on the assistance of investigators and other agents in the compilation of materials in preparation for trial. It is therefore necessary that the doctrine protect material prepared by agents for the attorney as well as those prepared by the attorney himself." *United States v. Nobles*, 422 U.S. 225, 238-39 (1975). Rule 26(b)(3)(B) codifies that interest in protecting work product by requiring that a court "protect against disclosure of the mental impressions, conclusions, opinions, or legal theories of a party's attorney or other representative concerning the litigation."

Rule 26(b)(3)(A) protects from discovery "documents and tangible things" that a party's attorney or other representative, including a consultant or agent – like Rue – prepare for trial. Litigation consultants may qualify as non-attorneys who are protected under the work-product rule. *In re Cendant Corp. Sec. Litig.*, 343 F.3d 658, 665 (3d Cir. 2003). In *Cendant*, the Third Court extended work-product privilege to conversations between an attorney, witness, and Dr. Phil McGraw, who had been hired as a trial consultant. *Id.* at 660, 668.

As held by multiple courts, the work-product doctrine "covers documents or the compilation of materials prepared by agents of the attorney in preparation for litigation." *United States v. Richey*, 632 F.3d 559, 567 (9th Cir. 2011); *see also In re Cendant Corp.*, 343 F.3d at 666 (rejecting the contention "that a non-attorney's advice regarding witness testimony does not fall under the work product doctrine"). Therefore,

communications between an attorney's agent and an expert are also protected. *See, e.g., In re Ford Motor Co.*, 110 F.3d 954, 967 (3d Cir. 1997) (the work product doctrine protected materials prepared by an in-house technical assistant for meetings to be attended by an outside technical consulting firm and lawyers regarding an issue in a product liability suit); *Martin v. Bally's Park Place Hotel & Casino*, 983 F.2d 1252 (3d Cir. 1993) (a technical report prepared by a consulting firm was protected from discovery because the document was prepared in anticipation of litigation by a party's representative (a consultant) for that party's representative (the company's in-house lawyer)); *United Coal Cos. v. Powell Constr. Co.*, 839 F.2d 958, 966 (3d Cir. 1988) (the work product doctrine extended beyond materials reflecting an attorney's mental impressions to encompass materials prepared in anticipation of litigation by a party's insurer); *Sprague v. Director, Office of Workers' Compensation Programs*, 688 F.2d 862, 869-870 (1st Cir.1982) (opinion letter setting forth expert's medical opinion was protected because it was prepared to advise counsel); *see also* Dennis P. Stolle et al., *The Perceived Fairness of the Psychologist Trial Consultant*, 20 Law & Psychol. Rev. 139, 169 (1996) ("Modern trial consulting methods typically consist of many techniques such as witness preparation, and mock trials, that clearly could not be framed as falling outside of the work product rule.").

1. Communications Generally

As OAG's agent, all documents created by Rue for this litigation are protected by the work-product privilege. FED. R. CIV. P. 26(b)(3)(A). The magistrate clearly erred in ruling otherwise.

Plaintiffs and the magistrate erroneously focus on Rule 26(b)(4)(C), which refers to communications between expert witnesses and "counsel's agents or employees," based on the Rule's advisory committee notes, citing the statement that "[t]he rule does not itself protect communications between counsel and other expert witnesses, such as those for whom disclosure is required under Rule 26(a)(2)(C) [an expert witness who does not have to provide a written report]." But Plaintiffs fail to cite the next sentence of the advisory committee's notes, which allows for "protection under other doctrines, such as privilege or independent development of the work-product doctrine." 2010 Advisory Committee Notes to Rule 26, ¶ 10. As demonstrated above, Rue is OAG's agent, and documents created by him are protected work product. Nothing in Rule 26(b)(4)(C) requires disclosure of communications between an attorney's agent, whether they be an in-house paralegal or a retained consulting expert, and the expert witnesses if the work-product privilege otherwise applies.

To the extent Rule 26(b)(4)(C) applies at all, production must be limited "facts or data" provided by Rule to the testifying expert. FED. R. CIV. P. 26(b)(4)(C)(ii). Magistrate Judge Austin has previously recognized

that limitation, but inexplicably chose not to apply it in this case. *Nat'l W. Life Ins. Co. v. W. Nat. Life Ins. Co.*, A-09-CA-711 LY, 2011 WL 840976, *1-*2 (W.D. Tex. Mar. 3, 2011) (requiring defendant to produce only "the 'facts or data' relied upon by [the expert witness] in forming his opinions" under Rule 26(a)(2)(B), and therefore only communications that included "facts or data" relied upon by the expert witness were subject to discovery"). Furthermore, as the Court recognized in *National Western*, any criticisms of the State's expert witnesses and their reports "can be adequately addressed at trial through cross-examination." *Id.* (internal quotation marks omitted).

Rue's communications with the State's expert witnesses should be protected in the same way a paralegal or other assistant or agent of the State's attorneys would be. The work-product doctrine "protect[s] material prepared by agents for the attorney as well as those prepared by the attorney himself." *Nobles*, 422 U.S. at 238-39. Rue's involvement in this case was essentially that of a specialized outside paralegal for the State, retained to assist the State's attorneys and experts in preparing for this case, and therefore documents created by him in the course of his duties are covered by the work-product doctrine. *See, e.g.*, *Fine v. Facet Aerospace Products Co.*, 133 F.R.D. 439, 445 (S.D.N.Y. 1990) ("[T]he work product of a paralegal is subject to Rule 26(b)(3), whether the paralegal is viewed as an extension of the attorney or as another representative of the party itself."). This is a sensible approach that recognizes the realities of

complex litigation, which often requires assistance of non-attorneys in preparation for trial. *Nobles*, 422 U.S. at 238-39.

The cases Plaintiffs cite for support are not precedential, are not binding on this Court, or are simply wrong. They are also distinguishable. In the *Ecuador* case, for example, the court ruled that communications between a third-party consultant and a testifying expert were subject to disclosure, but the court also held that "[c]ommunications between [the testifying expert] and his assistants and [the party's] attorneys are expressly protected as work product under Rule 26(b)(4)(C)." *In re Application of Republic of Ecuador*, 280 F.R.D. 506, 514 (N.D. Cal. 2012). There is no reason to protect communications with the expert's assistants, but not the attorneys' assistants.

The *Greenwood* case cited by Plaintiffs is likewise distinguishable because it concerned a party designating a consulting expert to be a testifying expert while also invoking the protections afforded communications with a consulting expert. The court declined to protect communications in that context because, otherwise, a "party would be able to communicate with an expert, have that expert form opinions, and then prevent the other party from discovering the factual basis of that opinion because the communications occurred while the expert was supposedly only a 'consulting expert.'" *Greenwood 950, LLC v. Chesapeake Louisiana, LP*, 10-CV-0419, 2011 WL 1234735 (W.D. La. Apr. 1, 2011). That is not the case here;

Rue is not and has not been designated as a testifying expert.

Finally, the *Chevron* case Plaintiffs cite is distinguishable because the court ordered disclosure only after concluding that "there is nothing to indicate that . . . the consulting expert[ ] is conveying the mental impressions and theories of counsel . . . – the material sought to be protected by the work product amendments to Rule 26." *Chevron Corp. v. Barnthouse*, No. 10-mc-00053 SSB (KLL), at 3 (S.D. Ohio Dec. 8, 2010). Unlike in *Chevron*, Rue has been privy to and conveyed to the State's experts information regarding the legal theories and trial plan of counsel for the State.

2. Drafts

To the extent any of the communications between Rue and the testifying experts contain drafts of reports, those drafts are protected from discovery. Federal Rule of Civil Procedure 26 was amended in 2010, in part, to provide greater protection for communications between counsel and testifying experts. 2010 Advisory Committee Notes to Rule 26, ¶ 3. Rule 26(b)(4)(B) now explicitly provides that drafts of any expert report, regardless of the form in which they were recorded, are privileged. The magistrate's ruling, however, refuses protection to those drafts unless they were "pass[ed] on" between OAG and the testifying experts for the State. The magistrate judge's order eviscerates the protections of the Rule and would

require attorneys to screen all non-attorney personnel from drafts of expert reports. That cannot be what the Rule intends. Drafts of the State's testifying experts' reports must remain privileged, even if sent to or by Rue.

CONCLUSION

The Court should grant the State's objections, deny the motion to compel, and allow the State to maintain work-product privilege over the documents in question.

Respectfully submitted.

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Dated: August 2, 2014

[Certificate Of Service Omitted]

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS,
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH, AUSTIN WOMAN'S HEALTH CENTER, KILLEEN WOMAN'S HEALTH CENTER, NOVA HEALTH SYSTEMS D/B/A REPRODUCTIVE SERVICES, AND SHERWOOD C. LYNN, JR., M.D., PAMELA J. RICHTER, D.O., AND LENDOL L. DAVIS, M.D. (ON BEHALF OF THEMSELVES AND THEIR PATIENTS),	§	CAUSE NO. 1:14-CV-284-LY
PLAINTIFFS,	§	
V.	§	
DAVID LAKEY, M.D. AND MARI ROBINSON (IN THEIR OFFICIAL CAPACITIES),	§	
DEFENDANTS.	§	

ORDER

(Filed Aug. 1, 2014)

Before the court in the above-styled and numbered cause is the State Defendants' Emergency Motion Objecting to Magistrate's Order on Motion to Compel filed August 1, 2014 at 2:30 p.m. (Clerk's Doc. No. 146). The State objects to the United States Magistrate Judge's July 31, 2014 Order (Clerk's Doc. No. 142) and seeks a ruling from this court by 4:00

p.m. today, August 1. The record reflects that, following a discovery-dispute hearing with the magistrate judge on July 31, 2014, the parties received the magistrate judge's Order at approximately 7:40 a.m. on Friday, August 1, 2014.

This court held a final pretrial conference at 9:30 a.m. on August 1, 2014, during which the court repeatedly asked both parties if there were additional issues to be raised with the court prior to the commencement of trial on August 4, 2014. Neither party mentioned the issues contained in the State's emergency motion nor did the State indicate that they intended to file an objection to the magistrate judge's Order. The court finds that the State waived its objection to the magistrate judge's Order.

IT IS THEREFORE ORDERED that Defendants' Emergency Motion Objecting to Magistrate's Order on Motion to Compel (Clerk's Doc. No. 146) is **DENIED**.

SIGNED this 1st day of August, 2014

/s/ Lee Yeakel
LEE YEAKEL
UNITED STATES
DISTRICT JUDGE

DAVID IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH; *et al.*,	)	
Plaintiffs,	)	CIVIL ACTION
v.	)	CASE NO. 14-CV-284-LY
DAVID LAKEY, M.D.; *et al.*,	)	
Defendants.	)	

JOINT STIPULATION TO FACTS

(Filed Aug. 4, 2014)

The parties hereby stipulate, solely for the purposes of the above-captioned action, to the truth of the following facts as of the date indicated below:

1. The following facilities are ambulatory surgical centers currently licensed by the State of Texas that perform abortions. These facilities will not be prevented by the ambulatory surgical center requirements of HB 2 from performing abortions after September 1, 2014.

Planned Parenthood South Austin Clinic
201 East Ben White Boulevard
Austin, Texas 78704

Southwestern Women's Surgery Center
8616 Greenville Avenue Suite 101
Dallas, Texas 75243

Planned Parenthood of
Greater Texas Star Clinic
6464 John Ryan Drive
Fort Worth, Texas 76132

Planned Parenthood Center for Choice
4600 Gulf Freeway
Houston, Texas 77023

Whole Woman's Health San Antonio
4025 East Southcross
Building 3, Suite 15
San Antonio, Texas 78223

Texas Ambulatory Surgical Center
2505 North Shepherd
Houston, Texas 77008

2. Planned Parenthood of Greater Texas Surgical Health Services in Dallas, Texas has obtained a license from the State of Texas and has reported its intention to open an ambulatory surgical center that performs abortions in August 2014.

3. At an undisclosed date in the future, Planned Parenthood of South Texas plans to open a licensed ambulatory surgical center in San Antonio, Texas. Planned Parenthood has announced its intention to open its San Antonio ASC in September 2014, but it is unknown whether the facility will open in September 2014.

4. No facility licensed by the State of Texas as an abortion facility currently satisfies the ASC requirement of HB 2. As a result, each of these facilities

will be prohibited from providing abortion services effective September 1, 2014.

5. Reproductive Services of Harlingen has not provided abortion services since the admitting privileges requirement of HB 2 took effect.

6. There are 433 licensed ambulatory surgical centers in Texas. Of these, 336 are "considered to be an existing licensed ASC" pursuant to 25 Tex. Admin. Code. § 135.51(a).

Dated: August 4, 2014

/s/ Stephanie Toti

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH; *et al.*,	)	
laintiffs,	)	CIVIL ACTION
v.	)	CASE NO. 14-CV-284-LY
DAVID LAKEY, M.D.; *et al.*,	)	
Defendants.	)	

DIRECT TESTIMONY OF
ANNE LAYNE-FARRAR, Ph.D.

(Filed Aug. 4, 2014)

ANNE LAYNE-FARRAR, Ph.D., under penalty of perjury, testifies as follows:

1. I currently serve as a Vice President in the Chicago office of Charles River Associates, Inc. ("CRA"), a leading economics, financial and strategic consulting firm headquartered in Boston. I am an economist whose academic research and professional specialties include antitrust, the economics of intellectual property, and economic cost-benefit analysis. Over the course of my professional career, I have advised clients on competition, intellectual property, regulation, and policy issues across a broad range of industries.

2. I hold a Ph.D in Economics from the University of Chicago, and I have considerable experience

conducting economic cost-benefit analysis. For example, prior to its enactment, I studied the cost-benefit impact of the Durbin Amendment to the Dodd-Frank Act on a bank only marginally qualifying for inclusion in the provisions; I analyzed the costs and benefits of a proposed law regarding labor union formation, the results of which I presented at a hearing conducted by the U.S. Senate Committee on Health, Education, Labor, and Pensions; and I conducted cost and benefit analysis of payment cards compared to paper instruments, regulations regarding the decommissioning of off-shore oil platforms in the Gulf of Mexico, and proposed online privacy regulation.

3. I have published articles in *Antitrust, Global Competition Review*, and *Regulation Magazine*, have coauthored a book on competition law and economics, and have numerous publications in academic journals, including *Harvard Journal of Law and Public Policy* and *International Journal of Industrial Organization.*

4. My curriculum vita, which sets forth my experience and credentials more fully, is annexed hereto as P-001. It contains a complete list of the publications that I have authored or co-authored during the past 10 years.

5. I am testifying as an expert in the field of Economics, and my opinions are based on my education, research, and writing in the field of economics; my review of the relevant literature; and my years of experience conducting economic cost-benefit analysis.

I have also consulted with a medical expert and reviewed the relevant medical and public health literature.

I. Background

6. Legislation known as Texas House Bill No. 2 ("the Act" or "HB2") was debated last year and was signed into law by Governor Perry on July 18, 2013. The bill, authored by Rep. Jodie Laubenberg (R-Parker) and carried by Sen. Glenn Hegar (R-Katy) establishes rules regulating the provision of abortion services within Texas.

7. These rules include the "ASC requirement," which provides, in relevant part, that "the minimum standards for an abortion facility must be equivalent to the minimum standards adopted under [Texas Health & Safety Code] Section 243.010 for ambulatory surgical centers."[1] Regulations to implement the ASC requirement were proposed on September 27, 2013,[2] and adopted on December 27, 2013.[3]

8. The ASC minimum standards are exhaustive, encompassing over 100 pages.[4] They include physical plant requirements, such as detailed specifications for

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[1] Tex. Health & Safety Code Ann. § 245.010(a).

[2] 38 Tex. Reg. 6536-46 (Sept. 27, 2013).

[3] 38 Tex. Reg. 9577-93 (Dec. 27, 2013).

[4] 25 Tex. Admin. Code Chapter 135 Ambulatory Surgical Centers Licensing Rules.

mechanical, plumbing, and electrical systems, and the configuration and size of various spaces.[5] For instance, the regulations require "commuting corridors"—those linking the operating room, preoperative holding area, and postoperative holding recovery suite—to be at least eight feet wide.[6] With certain exceptions, the minimum ceiling height must be eight feet six inches.[7]

9. The ASC regulations also detail a host of operating requirements. For instance, the new regulations impose stringent staffing regulations.[8] The minimum nurse staffing requirements include three different positions: director of the department, supervisors, and staff personnel.[9] A registered nurse with a cardiac life certification must be on the premises at all times. In addition, ASCs are required to keep detailed patient records and designate a staff member to be in charge of data collection, processing, maintenance, storage, retrieval, and distribution.[10]

10. Proponents of HB2 point to improved women's health and safety as the motivation behind the

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[5] 25 Tex. Admin. Code §135.52.

[6] *Id.* at 67.

[7] *Id.* at 69.

[8] *Id.* at 25.

[9] *Id.* at 26.

[10] *Id.* at 11.

Act as a whole and the ASC requirements in particular.[11]

A. Abortion Clinics That Will be in Operation After the ASC Requirement is Implemented

11. For purposes of this analysis, I assume based on the available evidence that when the ASC requirement takes effect on September 1, 2014, there will be fewer than 10 licensed abortion facilities remaining in Texas, clustered in the metropolitan areas of Houston, San Antonio, Dallas-Ft. Worth and Austin. As such, there will be no licensed abortion facilities within the state west or south of San Antonio. I further assume that, but for the ASC requirement, there would be licensed abortion facilities operating south or west of San Antonio, in Corpus Christi, McAllen, and El Paso as of September 1, 2014.

12. The 132 counties west or south of San Antonio contain 18.1% of the Texas female population aged 15-45 years. On average, these counties have a median income of $41,908, as compared to the state median of $51,563, and approximately 18.5% of the total population in these counties lives below the federal poverty line. These counties represent 44.4% of the state's Hispanic population.

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[11] http://www.hro.house.state.tx.us/pdf/fr2013/130709A.PDF at p.10.

13. Note that the counties of Hidalgo, Cameron, Starr and Willacy—all located in the Rio Grande Valley—are four of the poorest regions in Texas (see Table 1 below). Nearly 5% of Texas' female population aged 15-44 years lives in these four counties. The median income in Hidalgo and Cameron counties is less than $35,000 while the median income in Starr and Willacy counties is even lower, less than $27,000, compared to the overall median for Texas of over $51,000. Furthermore, in those four counties over 26% of women (18-44) have less than a high school education and over 35% of the population lives below the federal poverty line. The Hispanic population in these counties is over 87%.

Table 1. Demographic Information for Rio Grande V

County	Female Population (15-44)	Median Income (1)(a)
Cameron	85,711	$32,558
Hidalgo	171,134	$33,218
Starr	13,156	$24,653
Willacy	3,967	$26,369
Rio Grande Valley	273,968	$32,501
Texas (c)	**5,341,359**	**$51,563**

Notes: *(1) Demographics statistics refer to the listed coun*

Sources: *(a) Demographic data for the 254 individual Downloaded from NHGIS, https://data2.nhgis. (b) Demographic data for the largest 121 coun NHGIS, https://data2.nhgis.org/main. (c) Medi http://quickfacts.census.gov/qfd/states/48000.html*

II. Cost-Benefit Analysis of the ASC Requirement in HB2

14. I turn now to the analysis of the likely costs and benefits deriving from the ASC requirement. A cost-benefit analysis provides a systematic approach to assessing the strengths and weaknesses of any given policy decision or regulatory proposal. Well documented in the economics and legal literature,[12] a cost-benefit analysis exists as a neutral decision tool for objectively evaluating the social returns of any given proposed legislation or regulation. This tool has been a key element of policy decision making since the New Deal, when President Roosevelt's National Planning Board began to commission economic analysis of public works projects in 1934.[13] Congress first formally began to add language promoting cost-benefit analysis in the Flood Control Act of 1936, stating, "the Federal Government should improve or participate in the improvement of navigable waters . . . for flood-control purposes if the benefits . . . are in excess of the estimated costs."[14]

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[12] Graham, Daniel A. "Cost-benefit analysis under uncertainty." American Economic Review 71.4 (1981): 715-25; Kennedy, Duncan. "Cost-benefit analysis of entitlement problems: a critique." Stanford Law Review (1981): 387-445.; Brown, Darryl K. "Cost-benefit analysis in criminal law." California Law Review (2004): 323-372.

[13] Cole, Daniel. "Law, Politics, and Cost-Benefit Analysis" 64 Alabama Law Review (2012): 1-55.

[14] Flood Control Act of 1936, Pub. L. No. 74-738, § 1, 49 Stat. 1570, 1570 (1936).

15. While a cost-benefit analysis can be highly useful when done well, criticism often surrounds its use of value judgments that may prove subjective. For example, estimating the value of a human life is a common source of controversy in cost-benefit analyses.[15] For this reason, in forming my analysis of the costs and benefits of the ASC requirement within the HB2 legislation, I take the most conservative approach possible. In particular, I do not attempt to attach numbers to subjective factors and instead only discuss those qualitatively. This is the same approach taken by federal agencies when evaluating the costs and benefits of proposed regulations pursuant to Executive Order 13563 (Jan. 18, 2011).[16]

16. I first consider the potential benefits that could derive from the ASC requirements imposed by the Act in subsection A. I then discuss the likely costs imposed by the Act's ASC provision in subsection B. Finally, in subsection C, I weigh the costs against the benefits. I find no evidence supporting any measurable health or safety benefit for Texas women that is likely to derive from HB2's ASC requirement. Nor do I find any likely benefit of the provision for abortion

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[15] Revesz, Richard L. "Environmental regulation, cost-benefit analysis, and the discounting of human lives." Columbia Law Review (1999): 941-1017.

[16] Section 1(c) of Executive Order 13563 provides, in relevant part, that: "Where appropriate and permitted by law, each agency may consider (and discuss qualitatively) values that are difficult or impossible to quantify, including equity, human dignity, fairness, and distributive impacts."

providers. In contrast, I find significant burden and cost imposed on both abortion providers and Texas women as a result of the ASC requirement. I conclude that the costs outweigh the benefits.

A. The Potential Benefits Deriving From the ASC Provisions in HB2

17. The first step in the analysis is to determine whether and to what extent the ASC requirement benefits patients by improving the safety of abortions or whether it benefits abortion providers by increasing their net income. To determine whether or not either form of benefits is likely, we first need to understand the regulations applied to abortion clinics in Texas and the reported health risks associated with abortions prior to HB2. The additional requirements imposed by the ASC mandate can then be compared to the prior regulations and the potential benefits assessed.

(1) Existing Abortion Facility Licensing Requirements vs. HB2's ASC Requirements

18. The licensing and reporting of abortion clinics in Texas have been subject to Chapter 139 of Title 25 of Texas Administrative Code. Three types of abortion providers are exempt from these licensing and requirements, both before and after the passage of HB2: (1) hospitals licensed under Health and Safety Code, Chapter 241; (2) ASCs licensed under

Health and Safety Code, Chapter 243; and (3) private practice offices of physicians licensed by the Texas Medical Board and authorized to practice medicine in the State of Texas, provided the office is used for the purpose of performing fewer than 50 abortions in any 12-month period.[17]

19. Note that two of the exceptions listed above are of little practical relevance. Namely, while physician's offices can provide abortion services, private practice physicians very rarely do so. In 2007-2011, only 346 out of a total 384,119 abortions at less than 16 weeks of gestation in Texas were performed in a doctor's office (0.09%).[18] Likewise, very few abortions are performed at hospitals in Texas—only 0.09%.[19] As a result, clinics have to date performed the majority of abortions in Texas: based on data from 2007-2011, 89.8% were performed in abortion clinics, followed by 9.9% in ASC.[20]

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[17] 25 Tex. Admin. Code § 139.1(b)(1)(B).

[18] Texas Department of State Health Services, Table 37, "Induced Terminations of Pregnancy by Facility and Length of Gestation," For 2007 see http://www.dshs.state.tx.us/CHS/VSTAT/VS07/t37.shtm; For 2008 see http://www.dshs.state.tx.us/chs/VSTAT/latest/t37.shtm; for 2009 see http://www.dshs.state.tx.us/chs/vstat/vs09/t37.shtm; for 2010 see http://www.dshs.state.tx.us/chs/vstat/vs10/t37.shtm; for 2011 see http://www.dshs.state.tx.us/chs/vstat/vs11/t37.shtm.

[19] *Id.*

[20] *Id.*

20. In Texas, both abortion procedures and abortion providers were subject to strict regulatory requirements before the passage of HB2. First, 25 Tex. Admin. Code § 139.46 laid out specific requirements for the staff of abortion clinics that ensured that "[a] licensed abortion facility [had] an adequate number of personnel qualified . . . to provide direct patient care as needed by all patients; and administrative and nonclinical services needed to maintain the operation of the facility in accordance with the provisions of the Act." In particular, Section 139.46 required, among other things, that the medical staff include a physician, a registered nurse or a licensed vocational nurse, as well as trained education and information staff and laboratory staff.

21. Second, 25 Tex. Admin. Code § 139.48 listed specific physical and environmental requirements that ensured that the licensed abortion had a "safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients and staff at all times." Additional requirements stated that the facility had to properly equip procedure rooms "so that procedures can be performed in a manner that assures the physical safety of all individuals in the area," that the facility had "a separate recovery room if moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia are administered at the facility," and that the clinic "[had] equipment available to sterilize instruments, equipment, and supplies . . . before use in the facility."

22. Third, 25 Tex. Admin. Code § 139.49 further listed Infection Control Standards, "to minimize the transmission of post-procedure infections" such as "the transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus (HCV), Mycobacterium tuberculosis (TB), and Streptococcus species (S. spp.)." The section also established "educational course requirements; cleaning and laundry requirements; and decontamination, disinfection, sterilization, and storage of sterile supplies."

23. Abortion facility licensing requirements will become far more restrictive after the ASC requirement of HB2 is implemented. While the rules regarding abortions performed at hospitals or in physician offices that perform fewer than 50 abortions per year are unchanged, the only other facilities that can now obtain a license to perform abortions are facilities that meet the minimum standards for ASCs.[21] That is, before HB2, only abortions performed at 16 weeks of pregnancy or later were required to be performed in an ASC; after September 1, 2014, all abortions not performed in a hospital or physician's office must be performed in a facility that meets ASC standards. As explained above, the regulations for meeting ASC status are detailed and extensive (and costly, as explained in a subsequent section).

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[21] 25 Tex. Admin. Code § 139.4 3(d)(1).

(2) The Current Risks of Complication or Death Due to Abortion

24. Based on consultation with a medical expert and review of the relevant medical literature, I understand that today both surgical and medical abortions are quite safe. For the decade 2000 to 2009, the abortion-related mortality rate in the United States was 0.6 deaths per 100,000 legal abortions (or 0.0006%).[22] In fact, the risk of death from abortion is far lower than the risk of death from childbirth, which is 8.8 deaths per 100,000 live births (or 0.0088%).[23] Thus, the risk of death from childbirth is around 14 times higher than the risk of death from abortion.

25. I also understand that complications arising from abortion procedures are rare. In a study of 11,487 women receiving an abortion at one of 22 clinics in California between 2006 and 2011, serious

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[22] Raymond, Elizabeth G., and David A. Grimes. "The comparative safety of legal induced abortion and childbirth in the United States." Obstetrics & Gynecology 119.2, Part 1 (2012): 215-219 (P-087). See also Jones, Bonnie Scott, and Tracy A. Weitz. "Legal barriers to second-trimester abortion provision and public health consequences." American Journal of Public Health 99.4 (2009): 623, citing Grimes, DA, "Estimation of pregnancy-related mortality risk by pregnancy outcome, United States 1991—1999", American Journal of Obstetrics and Gynecology, 2006; 194(1): 92-94.

[23] Raymond, Elizabeth G., and David A. Grimes. "The comparative safety of legal induced abortion and childbirth in the United States." Obstetrics & Gynecology 119.2, Part 1 (2012): 215-219 (P-087).

complications—that is complications requiring admission to a hospital, surgery, or a blood transfusion—were reported for only 6 women.[24] That translates to a serious complication rate of only 0.05%. In a study that examined medical abortions (i.e., those using medications, typically mifepristone and misoprostol, to induce abortion, as opposed to employing a surgical procedure) the risk of serious complications was similarly low. Out of a total of 45,528 women receiving a medical abortion, only 0.3% was hospitalized and only 0.1% received blood transfusions.[25] No deaths were reported in these trials.

26. As further evidence of the safety of current abortion practices, consider reported investigations and reprimands of abortion providers. In 2013, a Congressional committee conducted an inquiry concerning how states regulate abortion providers. Texas' response to this inquiry indicated that only sixteen violations were alleged at abortion clinics between 2008 and 2013 and all but one involved bureaucratic infractions, such as failure to post the license number in advertisements or failure to submit the annual report required by the Department of State Health

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[24] Weitz, Tracy A., et al. "Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives, and physician assistants under a California legal waiver." American journal of public health 103.3 (2013): 454-461.

[25] Raymond, Elizabeth G., et al. "First-trimester medical abortion with mifepristone 200 mg and misoprostol: a systematic review." Contraception 87.1 (2013): 26-37.

Services. None of these violations related to any serious health risk.[26]

(3) The Potential for HB2 to Lower the Risks of Complication or Death Resulting From an Abortion

27. The public health literature suggests that HB2's ASC requirement is unlikely to provide any health benefits to Texan women. As stated by Jones and Weitz (2009), "No data exist to show that providing abortions in ASCs positively affects complication rates or patient health outcomes or that physician's offices and outpatient clinics are inadequate or unsafe facilities for performing abortions. ASC regulations also go far beyond the guidelines for abortion provision issued by professional organizations such as the American College of Obstetricians and Gynecologists and the National Abortion Federation."[27]

28. This is not surprising given that the additional construction mandates imposed by the ASC requirement are inapposite to the performance of abortion procedures. For example, I understand that the requirements concerning configuration of the

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[26] Culp-Ressler. "Republicans' own investigation into 'dangerous' abortion clinics discovers they're already very safe." Think Progress. Available at http://thinkprogress.org/health/2013/08/21/2502111/republicans-investigation-abortion-clinics/.

[27] . Jones, Bonnie Scott, and Tracy A. Weitz. "Legal barriers to second-trimester abortion provision and public health consequences." American Journal of Public Health 99.4 (2009): 623.

surgical suite and adjacent areas, such as the requirement that there be a restricted corridor with scrub facilities outside the operating room(s), are aimed at providing the degree of sterile precaution that is appropriate for a surgical procedure requiring an aseptic surgical field. The same is true of many of the other construction requirements, including those concerning air filtration, humidity control, and floor, wall, and ceiling finishes. But abortion procedures do not entail an aseptic surgical field.[28] Accordingly, these construction requirements provide no benefit to abortion patients.

29. Similarly, the additional staffing mandates imposed by the ASC requirement are unnecessary to the performance of abortion procedures. I understand that existing regulations, which mandate "an adequate number of personnel qualified . . . to provide direct patient care as needed by all patients," including but not limited to "a physician, a registered nurse or a licensed vocational nurse, as well as trained information staff and laboratory staff' are sufficient to ensure that a facility is able to provide the standard of care for pre-16 week abortion procedures. I've been informed that such procedures are short in

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[28] Meckstroth, K and M. Paul "First-trimester aspiration abortion, in Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care." Blackwell Publishing Ltd., 144 (2009) (P-083). ("Wearing sterile gloves does not assure asepsis because contamination occurs as soon as the gloved hands come in contact with the patient. In addition, eradicating the natural microflora of the vagina is impossible.")

duration, lasting only 2-10 minutes; do not require an incision or suturing; are performed without general anesthesia; and require patients to spend less than one hour in a recovery room. The additional staff mandated by the ASC requirements, including multiple registered nurses, adds no benefit to the provision of abortion care.

30. Prior studies comparing the mortality risk of abortions at hospitals as compared to clinics are consistent with the conclusion that the ASC requirement does not improve the health and safety of women seeking an abortion within Texas. Hospitals have even stricter licensing requirements than ASCs,[29] and yet a study of abortion-related deaths showed the mortality rate was essentially identical for hospitals and clinics.[30]

31. The evidence therefore indicates that the ASC requirement imposed by HB2 is unlikely to have any measurable benefits in terms of reduced risk of death or serious complications arising from abortion procedures, and as such are unlikely to offer any meaningful improvements in the quality of care provided to women obtaining abortions at Texas abortion

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[29] 25 Tex. Admin. Code Chapter 133 Hospital Licensing Rules.

[30] Grimes, David A., Willard Cates, and Richard M. Selik. "Abortion facilities and the risk of death." *Family planning perspectives* (1981): 30-32. The data for this study covers mid to late 1970s. The mortality rate was found to be 0.6, identical to the rate for 1998-2006 reported above (see supra note 23).

facilities as compared to the licensing requirements in place before the Act was passed. Given how low the risk rates are today, without the added restrictions of HB2, there is little room for meaningful improvement in the first instance.

32. Moreover, to the extent that concerns (whether warranted or unwarranted) about lack of compliance with existing regulations are part of the motivation for HB2, making those regulations more stringent is not the best response to achieve the desired goal. Supporters of the ASC requirement have cited the example of a Pennsylvania doctor convicted of criminal acts as evidence of the need for increased regulation of facilities where abortions are performed.[31] But if an aberrant doctor failed to abide by existing regulations, why should we expect that doctor to abide by new, stiffer regulations? Instead, the economic literature establishes that increased enforcement and strengthened repercussions are the best ways to achieve better compliance.[32]

33. Notably, under existing regulations, abortion facilities receive unannounced inspections from the Texas Department of State Health Services on an

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[31] http://www.hro.house.state.tx.us/pdf/fr2013/130709A.PDF at p.10.

[32] Becker, Gary S. "Crime and punishment: An economic approach." Essays in the Economics of Crime and Punishment. UMI, 1974. 1-54; Stigler, George J. "The optimum enforcement of laws." Essays in the Economics of Crime and Punishment. UMI, 1974. 55-67.

annual basis, as well as when complaints are made.[33] ASCs, in contrast, are only subject to inspection once every three years and for cause.[34] Thus, the ASC requirement in HB2 does not provide additional mechanisms to detect non-compliance. Nor do they provide increased incentives for compliance. Violations of the ASC regulations are subject only to administrative penalties; whereas, violations of existing abortion facility regulations are subject to criminal sanctions as well as administrative penalties.[35]

34. In sum, the available evidence offers no support for improved health and safety as a result of the ASC requirement.

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[33] http://rhrealitycheck.wpengine.netdna-cdn.com/wp-content/uploads/state-abortion-docs/Departments-of-Health/Texas/Texas_Department_of_Health_1.pdf.

[34] 25 Tex. Admin. Code § 135.21.

[35] See 25 Tex. Admin. Code § 135.24(d) ("The department may impose an administrative penalty on a person licensed under this chapter who violates the Act, this chapter, or order adopted under this chapter.") and 25 Tex. Admin. Code § 139.33 (b). ("Injunction, criminal penalties, and civil penalties. In addition to administrative penalties, the Health and Safety Code, Chapter 245, provides for injunctive relief and civil penalties for violations of that chapter and violations of these rules and also provides for criminal penalties for certain violations described therein.").

(4) The Potential for Benefits to Accrue to Abortion Providers as a Result of HB2's ASC Requirement

35. Turning next to abortion providers, it does not appear that converting an existing abortion facility to an ASC would enable that facility to increase its net income. The available evidence indicates that the prices set for abortion procedures conducted at ASCs, holding the weeks of gestation at the date of the procedure constant, are higher. However, such price differentials could be driven by cost differentials. As I explain below, the costs of running an ASC are in fact higher than the operational costs for non-ASC clinics. I am unaware of any studies that indicate women prefer to obtain an abortion from an ASC as opposed to a non-ASC clinic, which would allow ASC's to charge higher prices unrelated to cost-driven increases. Indeed, as reported above, the majority of abortions in Texas are performed at non-ASC clinics, suggesting that women prefer these facilities to ASCs.[36]

36. Moreover, the above discussion is premised on abortion providers in the affected clinics being able to open an ASC. In addition to being more costly to operate, however, ASCs are also more costly to build than non-ASC abortion clinics. As a result, it is unlikely that the locations losing non-ASC clinics will see new ASCs built to replace the prior clinics.

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[36] See paragraph 14 above.

37. While data is sparse, I have seen no evidence that would suggest any benefit of HB2's ASC requirement would accrue to abortion providers.

B. The Costs Imposed by the ASC Provisions in HB2

38. Though the ASC provisions in HB2 are unlikely to yield any discernable health or safety benefits for women receiving abortions in Texas, nor any benefits to net income for abortion providers in Texas, the provisions are likely to impose a number of costs on both abortion providers and women seeking an abortion at a licensed abortion facility within Texas.

(1) The Costs of Meeting the ASC Requirement for Abortion Providers

39. As an initial matter, available evidence indicates that the existing non-ASC abortion facilities within Texas will all close by September 1, 2014. I understand that space limitations, the high cost of retrofitting to meet ASC requirements (in excess of $1 million), or both will prevent existing facilities from renovating to meet the new licensing requirements. Furthermore, the high cost of building a new ASC (which is expected to exceed $3 million) will limit new facilities from emerging to fill the void left by the closure of current clinics.

40. As a result of the many additional staffing requirements (noted above), it is not surprising that

the operational costs for an ASC exceed those for a non-ASC abortion clinic. While relevant data is quite limited, my research to-date indicates that the incremental cost of operating an ASC for abortion services is between $607,085 to $1,039,372 higher per year than the analogous cost of operating a non-ASC abortion clinic.[37]

41. Indeed, given the high cost of building a new ASC or of operating an existing ASC, it would be difficult for smaller cities, like El Paso or McAllen, to support one as the surrounding populations are unlikely to generate sufficient demand to sustain an ASC.[38] In fact, even though prior legislation limited abortions post-16 weeks gestation to ASCs, only the four largest metropolitan areas in Texas (Dallas-Ft. Worth, Houston, San Antonio, and Austin) currently support ASCs that provide abortion services. As a result, the ASC requirement can be expected to

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[37] *Id.*

[38] Note that this is consistent with the result of prior legislation in Texas in 2003 that limited abortions at 16 weeks or more to be performed at ASCs. In the wake of that legislation, ASCs were opened in the larger metropolitan areas only and none have been opened west or south of San Antonio. See Table 1 in Published: Colman, Silvie and Ted Joyce. 2011. "Regulating Abortion: Impact on Patients and Providers in Texas." *Journal of Policy Analysis and Management* 30(4):775-797 (P 152). In 2001-2004 223,377 abortions out of all 224,226 (99.6%) abortions to TX residents were performed at abortion clinics vs. 212,156 abortions performed at clinics out of all 224,621 abortions to TX. residents in 2004-2006.

reduce the accessibility of abortion services for women living outside these large urban centers.

(2) ASC Requirements Will Lead to a Direct Increase in the Cost of Abortions

42. As a simple matter of economics, reducing the supply of a product or service (shifting the supply curve to the left) increases the cost of that product or service. Therefore, because HB2 will almost certainly reduce the supply of abortion facilities in Texas, it will also lead to higher explicit costs for those women able to reach a Texas facility and obtain an abortion.

43. This outcome was clearly seen as a result of a prior Texas abortion law. In particular, the Women's Right To Know Act, passed in 2003 in Texas, required that abortions at 16 weeks gestational age or later must be performed in an ASC.[39] Charges for abortions at 20 weeks rose approximately 37% (by around $454) after the Act passed, relative to other states.[40]

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[39] See http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.171.htm ("Sec. 171.004. ABORTION OF FETUS AGE 16 WEEKS OR MORE. An abortion of a fetus age 16 weeks or more may be performed only at an ambulatory surgical center or hospital licensed to perform the abortion.").

[40] Colman, Silvie, and Ted Joyce. "Regulating abortion: Impact on patients and providers in Texas." *Journal of Policy Analysis and Management* 30.4 (2011): 775-797 (P-152). While I cannot calculate an overall cost burden for the ASC provision, due to many costs that cannot be readily quantified, I include

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44. Adding to the simple supply and demand point is the increased cost to abortion providers of meeting ASC requirement. Again, as a matter of economics, increasing the operational costs of providing a service will generally lead to an increase in the price of that service.

(3) Reduced Access to Licensed Abortion Facilities Will Raise Abortion Access Costs for Women Seeking Abortions

45. Reducing the number and geographic distribution of abortion providers will also impose a significant burden on women who no longer have access to nearby abortion facilities within a reasonable driving distance. For example, the median driving distance to the nearest abortion facility post September 1, 2014, for women living in the Rio Grande Valley is 237 miles, compared to the 41 mile trip to reach the abortion facility in McAllen, had that clinic been allowed to remain open. Figure 1 below illustrates the minimum driving distances to the nearest abortion facility post-September 1, 2014 for women living in the Rio Grande Valley compared to what it would be if the abortion facility in McAllen were able to remain open.

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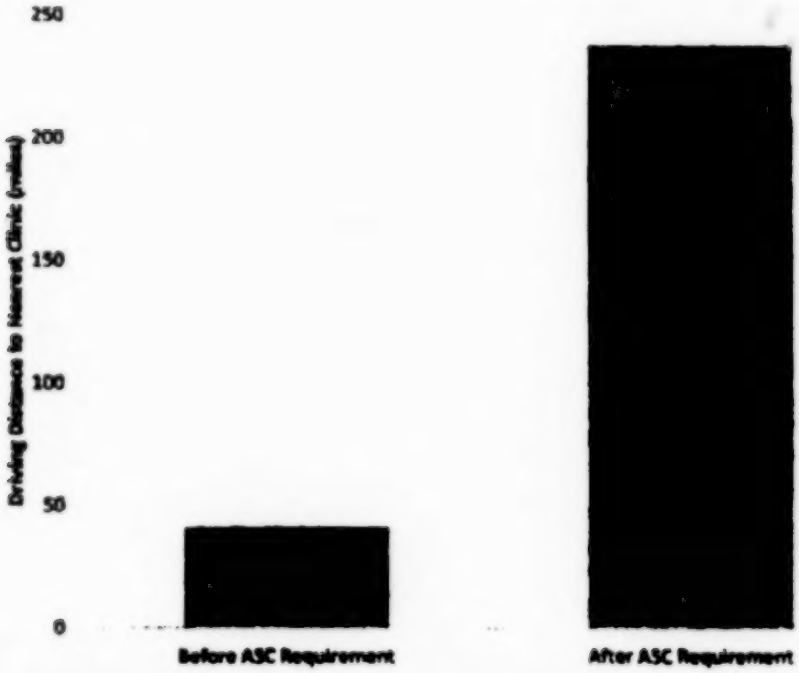
this specific increase as a illustrative of the significance of the price effect that is likely to result after September 1, 2014.

Figure 1. Driving Distances to Nearest Abortion Clinic, Rio Grande Valley



46. Although women in the Rio Grande Valley will likely experience the greatest costs, the reduced availability of abortion facilities will impose costs on all Texas women, while the increased distances to reach an ASC will impose costs on all those living outside the 4 metropolitan areas.

47. The increased distances noted above will lead to several incremental expenses imposed on women living in western and southern Texas seeking access to an ASC abortion clinic. First, the greatly increased distances to reach the nearest abortion facility will mean longer driving times and greater fuel costs for women living west or south of San Antonio. Table 2 below reports the incremental driving

distances and times by county and the medians for the Rio Grande area as a whole.

Table 2. Incremental Driving Distance and Time to Abortion-Seekers after the ASC Requirement is Implemented

Rio Grande County	Female Population (15-45)	Driving Distance Increase (miles, one way)	Driving Time Increase (minutes, one way)
Starr County	13,156	181.4	158.0
Hidalgo County	171,134	211.6	174.0
Willacy County	3,967	179.1	145.0
Cameron County	85,711	212.6	172.0
Rio Grande Valley	273,968	197.0 (median)	165.0 (median)

48. When the nearest abortion provider is more than 200 miles away, patients will be unable to make the trip in a single day and instead will need to stay at a hotel in the ASC city. Longer driving times will also lead to the extra cost of meals while traveling and away from home. In addition, longer drive times will mean increased lost wages for those hours traveling and away from home and the cost of childcare for those women who have children at home. While the increased expenses of accessing a licensed abortion facility discussed above are measurable, because the more significant costs imposed by the ASC requirement are not, as discussed next, it would be

misleading to present dollar figures here as no aggregate dollar figure could be presented for the summary.

(4) HB2 Can Be Expected to Increase Delay in Women Receiving Abortion Services, Which Increases Women's Health Risks

49. Prior studies have established that increased cost and difficulty of reaching an abortion facility lead to delays in women having an abortion procedure. As one study observed, "Comparing broad categories of reasons for abortion delay, women with second-trimester abortions reported more logistical delays (63%), such as difficulty locating a provider, initially being referred elsewhere, or difficulty arranging transportation, compared with 30% in the first trimester."[41] Another study noted that the most common reasons for delay in obtaining an abortion are travel and procedure costs.[42]

50. In other words, empirical studies indicate that the greater the distance a woman has to travel to reach an abortion clinic, the later the gestational

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[41] These results were highly statistically significant ($p < .001$). Foster, Diana G., et al. "Predictors of delay in each step leading to an abortion." *Contraception* 77.4 (2008): 289-293.

[42] Upadhyay, Ushma D., et al. "Denial of Abortion Because of Provider Gestational Age Limits in the United States." *American Journal of Public Health* 0 (2013): e1-e8 (P-156).

period is likely to be at the time the abortion is performed.[43] While risks associated with abortion procedures are low throughout pregnancy (particularly in relation to the risks associated with childbirth, as described above), later abortions do have a higher risk of complications than earlier abortions.[44] More specifically, the mortality rate among women who had abortions in the first trimester (90% of abortions in the U.S.) was less than 0.4 deaths per 100,000 procedures (0.0004%).[45] For less than 8 weeks gestational age as measured from a woman's last menstrual period or LMP (66% of U.S. abortions), only 0.1 deaths were reported per 100,000 procedures (0.0001%).[46]

51. Hence, because it can be expected to increase delay in obtaining an abortion, the ASC requirement in HB2 can also be expected to increase the risk of complications for women receiving an abortion. That is, rather than decrease the risks of complications that women face from abortion procedures, the ASC

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[43] Foster, Diana G., et al. "Predictors of delay in each step leading to an abortion." *Contraception* 77.4 (2008): 289-293.

[44] Bartlett, Linda A., et al. "Risk factors for legal induced abortion—related mortality in the United States." Obstetrics & gynecology 103.4 (2004): 729-737 (P-098); S. V. Gaufberg, "Abortion complications," 2008, http://emedicine.medscape.com/article/795001-overview (last visited May 31, 2012.

[45] Bartlett, Linda A., et al. "Risk factors for legal induced abortion—related mortality in the United States." Obstetrics & gynecology 103.4 (2004): 729-737 (P-098).

[46] *Id.*

requirement can be expected to increase those risks by delaying procedures.

52. Of course, delay may mean that some women are no longer eligible to receive a legal abortion, which in Texas must be performed at 20 weeks or less post-fertilization age. As HB2 now requires that all abortions outside of hospitals or private physician offices be performed in an ASC, as opposed to just those at 16 or more gestational weeks, the distance and cost of reaching a licensed facility post-HB2 may push some women seeking an abortion past the 20 week cutoff. Whereas those near but below the 16 week mark in southern or western Texas could have visited a clinic, they will now need to travel significant distances to reach one of the ASCs in the eastern metropolitan areas. Women unable to reach an ASC in time will have few options: attempt self-induced abortion, seek an illegal abortion, or carry an unwanted pregnancy to term.

53. These options impose costs of their own.[47] A recent study found that "Where abortion laws are liberal there is generally no or very little evidence of unsafe abortion and related morbidity and mortality. In contrast, legal restrictions result in women self-inducing abortion or seeking it clandestinely."[48]

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[47] Colman, Silvie and Ted Joyce. 2011. "Regulating Abortion: Impact on Patients and Providers in Texas." *Journal of Policy Analysis and Management* 30(4):775-797 (P-152).

[48] Iqbal H. Shah, Elisabeth Åhman and Nuriye Ortayli, "Access to Safe Abortion: Progress and Challenges since the

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Moreover, as noted above, carrying a pregnancy to term entails a risk of death that is nearly 14 times greater than having a legal induced abortion.

54. While self-induced attempts at abortion are not common today, they are not rare either. A nationally representative study found that 2.6% of women seeking an abortion had attempted to induce an abortion on their own.[49] For women going to clinics near the Mexican border, however, the figure is over five times higher, at 12%.[50] The confluence of limited access to abortion facilities, extreme poverty, and proximity to Mexico (where a known self-induction medicine, misoprostol, is readily available and frequently used) explain the differential.[51] Recall from above that the ASC requirements will result in the closure of all existing abortion facilities west and south of San Antonio, including the entire Texas border with Mexico. Note that misoprostol can also be purchased on the black market throughout Texas, or on the internet.[52]

1994 International Conference on Population and Development (ICPD)," 2014, p. 4.

[49] Grossman, Daniel, et al. "The public health threat of anti-abortion legislation." *Contraception* (2013).

[50] *Id.*

[51] *Id.*

[52] Deprez, Esme. "Legal abortions made harder, Texans turn to flea market pills." *Bloomberg* (July 11, 2013). Available at http://www.bloomberg.com/news/2013-07-11/flea-market-abortions-thrive-as-texas-may-close-clinics.html.

55. While using misoprostol can be a safe means of inducing abortion in the first trimester, if uninformed women use the wrong dosage it may not work, with the continued pregnancy going unnoticed until the second trimester, where the use of misoprostol is risky and can lead to hemorrhaging.[53] Nor is misoprostol the only method for self-induced abortion. Other methods include untested and unsafe herbs and invasive procedures.[54] Thus, to the extent that the increased distance and cost of reaching a licensed ASC drives women to attempt self-induced abortion, the result of HB2 will be to increase health risks to women. Should HB2 motivate women to seek illegal abortions—performed wholly outside of the safety regulations imposed by either HB2 or the previous regulation, that result would clearly increase health risks to women as well.

C. Weighing the Costs Against the Benefits

56. As the evidence presented above makes clear, HB2 offers no discernable benefits to either reproductive age women in Texas or abortion providers, but it does impose significant costs on many of them.

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[53] Grossman, Daniel, et al. "The public health threat of anti-abortion legislation." *Contraception* (2013) (P-105).

[54] Grossman, Daniel, et al. "Self-induction of abortion among women in the United States." *Reproductive health matters* 18.36 (2010): 136-146 (P-160).

57. Table 3 below summarizes the costs discussed above for the population of women that will be most burdened: those living west or south of San Antonio. While dollar figures cannot be attached to the many health costs, such as the increased health risks for women who delay abortions, carry unwanted pregnancies to term, or attempt self-induced or illegal abortion as a result of the greater travel distances needed to reach a licensed facility and the increased costs of obtaining a legal abortion at an ASC, these costs are no less real, and in fact are likely to represent the most significant of the costs imposed by the Act.

Table 3. Expected Costs and Benefits for ASC Requirement.

Party	Expected Benefits From the ASC Requirement	Expected Costs from the ASC Requirement
Abortion Providers	None—no expected increase in net income	Cost of retrofitting an existing facility so high (> $1M) that little to no retrofitting is expected Cost of building a new ASC: > $3M Cost of operating an ASC > cost of operating a non-ASC abortion facility (by $607,085 to $1,039,372 per year)

Abortion Patients	None—no expected improvement in health or safety, no anticipated reduction in rate of serious complications or death	Reduced supply of abortion facilities, particularly west and south of San Antonio Increased price of abortion procedures Increased cost of accessing abortion facilities, due to reduced supply and greater distances to travel, particularly for women west and south of San Antonio Increased health risks to women delaying an abortion procedure due to greater distances and increased costs, particularly for women west and south of San Antonio Increased health risks to women unable to obtain a legal abortion due to delay in seeking one as a result of greater distances and increased costs, particularly for women west and south of San Antonio

58. HB2's ASC licensing requirement for all abortion facilities appears to impose an unreasonable mandate that does not derive from medical evidence

and will impose costs on women seeking abortion services in Texas that are far in excess of any expected benefits. Similarly, the ASC requirement in HB2 also imposes significant costs on abortion providers, again with no offsetting benefits. In sum, the costs imposed by HB2's ASC requirement will be large while the benefits will be nonexistent.

III. Benchmarking the Regulatory Burdens Imposed by HB2 Against Other Clinical Procedures

59. Section II above presented the likely benefits and costs resulting from the implementation of the ASC requirement within HB2. In this section, I consider another outpatient clinical procedure as a benchmark against which to evaluate HB2's ASC licensing requirement.

60. The primary question assessed is whether the regulations imposed on abortion facilities are in line with regulations imposed on other procedures with similar or higher risk rates. If the regulations imposed on abortion facilities are significantly more onerous than those imposed on another procedure with similar or higher risk rates, that evidence would reinforce the conclusion above, that the burdens imposed by HB2 are unreasonable. Moreover, the extent to which another outpatient procedure with a similar or higher risk rate is not as heavily regulated as abortions suggests discrimination against women

seeking an abortion vis-à-vis other Texas constituents.

61. I evaluate the colonoscopy procedure as comparable to abortion in terms of invasiveness and risk rates. As the evidence presented below makes clear, colonoscopy is not as heavily regulated as abortions are, and yet entails higher risks.

A. Colonoscopy

62. A colonoscopy is a test that allows a physician to look at the inner lining of the large intestine using a long, flexible, narrow tube with a light and tiny camera on one end. This procedure is used to identify ulcers, colon polyps, tumors, and inflamed areas, as well as to screen for color cancer.[55] For this reason, the American Cancer Society recommends that beginning at the age of 50, men and women undergo a colonoscopy once every ten years to detect cancer.[56] It is estimated that colonoscopy screenings

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[55] "What is a Colonoscopy?." WebMD (December 7, 2011). Available at http://www.webmd. com/colorectal-cancer/colonoscopy-16695.

[56] "Guidelines for the Early Detection of Cancer." American Cancer Society (May 3, 2013). Available at http://www.cancer.org/healthy/findcancerearly/cancerscreeningguidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer.

have the potential to prevent about 65% of colon cancer cases.[57]

63. Roughly 15 million colonoscopies are performed annually in the United States.[58] Even though up to 33% of patents report minor gastrointestinal (GI) symptoms after the procedure, serious complications are rare. According to a 2008 study, the adverse event rate was 2.8 per 1,000 procedures, or 0.28%.[59] A 2010 study measures the colonoscopy-specific death rate to be 0.007%.[60] Complications from the procedure include perforation, hemorrhage, postpolypectomy coagulation syndrome and infections. The most serious among these is gastrointestinal perforation, which is life threatening and requires immediate surgery to repair. However, the incidence rate for this complication is only 0.082%.[61]

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[57] "Colorectal Cancer Facts & Figures 2011-2013." American Cancer Society (2013). Available at: http://www.cancer.org/acs/groups/content/@epidemiologysurveilance/documents/document/acspc-028323.pdf.

[58] Hewett, David, Charles Kahi and Douglas Rex. "Does Colonoscopy Work?" *Medscape* (2010). Available at http://webcache.googleusercontent.com/search?q=cache:V25_GujcwIsJ:www.medscape.org/viewarticle/714469+&cd=2&h1=en&ct=clnk&gl=us.

[59] "Complications of Colonoscopy." American Society of Gastrointestinal Endoscopy (2011). Available at http://www.asge.org/assets/0/71542/71544/56321364-c4d8-4742-8158-55b6bef2a568.pdf.

[60] *Id.*

[61] Arora, Gaurav, et al. "Risk of perforation from a colonoscopy in adults: a large population-based study." *Gastrointestinal Endoscopy* 69.3 (2009): 654-664. Available at http://www.giejournal.org/article/S0016-5107 (08)02591-1/abstract.

64. In comparison, recall that the mortality risk associated with abortions is 0.6 deaths per 100,000 procedures. Hence, the risk of death is roughly 10 times higher for a colonoscopy than an abortion. And yet, there are no regulations restricting the performance of a colonoscopy to an ASC.

65. If appropriate regulations to ensure the health and safety of women were a key goal in Texas regulation, one would expect those regulations to target procedures with relatively high risk rates. Focusing on procedures with the greatest risk would offer the greatest benefits to women in Texas. We do not see such a result, however. Instead, abortion is regulated to a much greater extent than other procedures performed in clinics, like colonoscopy, that entail greater risks to the patient.

Dated: August 3, 2014
Austin, Texas

By: /s/ Anne Layne-Farrar
Anne Layne-Farrar, Ph.D.

No. 15-274

Supreme Court, U.S.
FILED
DEC 28 2015
OFFICE OF THE CLERK

In The Supreme Court of the United States

WHOLE WOMAN'S HEALTH ET AL. PETITIONERS

v.

KIRK COLE, M.D., COMMISSIONER OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

JOINT APPENDIX VOLUME II

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH; *et al.*, Plaintiffs, v. DAVID LAKEY, M.D.; *et al.*, Defendants.	)	CIVIL ACTION CASE NO. 14-CV-284-LY

DIRECT TESTIMONY OF DANIEL GROSSMAN, M.D.

(Filed Aug. 4, 2014)

DANIEL GROSSMAN, M.D., under penalty of perjury, testifies as follows:

1. I am a board-certified obstetrician-gynecologist; an Assistant Clinical Professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco (UCSF); and a Fellow of the American College of Obstetricians and Gynecologists (ACOG), where I recently completed a term as Vice Chair of the Committee on Practice Bulletins for Gynecology. I am currently a member of the ACOG Committee on Health Care for Underserved Women. I am also a Fellow of the Society of Family Planning and a member of the American Medical Association (AMA) and the American Public Health Association (APHA).

2. I provide clinical services, including abortion care, as a consultant to Planned Parenthood Shasta Pacific, and I serve as a liaison member of the Planned Parenthood Federation of America National Medical Committee.

3. In addition, I serve as Vice President for Research at Ibis Reproductive Health, a nonprofit research organization. My research is supported by grants from federal agencies and private foundations. I have published over 85 articles in peer-reviewed journals, and I am a member of the Editorial Board of the journal *Contraception*.

4. I earned a B.S. in Molecular Biophysics and Biochemistry from Yale University and an M.D. from Stanford University School of Medicine. I completed a residency in Obstetrics, Gynecology, and Reproductive Sciences at UCSF.

5. My curriculum vitae, which sets forth my experience and credentials more fully, is annexed hereto as Exhibit P-002. It contains a complete list of the publications that I have authored or co-authored.

6. I am testifying as an expert in the fields of obstetrics and gynecology, abortion care, and public health. My opinions are based on my education, clinical training, sixteen years of experience as a practicing physician, attendance at professional conferences, my own medical research, and regular review of other medical research in my field.

7. I am familiar with the requirements of Texas House Bill No. 2 ("HB2"), including the "admitting privileges requirement," which mandates that all physicians who provide abortion services "have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced," and the "ASC requirement," which mandates that "the minimum standards for an abortion facility must be equivalent to the minimum standards for ambulatory surgical centers" under Texas law.

Impact of Abortion Facility Closures on Texas Women's Access to Legal Abortion Services

8. I am a Co-Investigator of the Texas Policy and Evaluation Project, which is a research project undertaken jointly by the University of Texas at Austin, Ibis Reproductive Health and the University of Alabama at Birmingham. Since 2011, the Texas Policy Evaluation Project has been tracking the number of open facilities providing abortion care in the state by intermittently requesting information from the Texas Department of State Health Services (DSHS) on licensed abortion providers. Through interviews with clinic staff and review of publicly available information, we identified clinics that ceased providing abortion services during the three time periods: (1) November 1, 2012 through April 30, 2013; (2) May 1, 2013 through October 31, 2013; and (3) November 1, 2013 through April 30, 2014. We did not include hospitals or physicians not licensed as an

abortion facility in our analysis because they perform only a very small percentage of abortions in Texas. In 2012, this percentage was 0.3%. We also calculated changes in the distance that reproductive age women in Texas must travel to access a licensed Texas abortion provider, as well as changes in the abortion rate during this time frame.

9. Our findings were recently accepted for publication by the peer-reviewed journal, *Contraception.*

10. There were 41 facilities in Texas providing abortion care during November 1, 2012-April 30, 2013 (Period 1). Eight of these closed or stopped providing abortion services during the period from May 1, 2013-October 31, 2013 (Period 2), and a net of 11 facilities closed or stopped providing abortion services during the period from November 1, 2013-April 30, 2014 (Period 3). Thus, from May 1, 2013, through April 30, 2014, 19 of 41 facilities closed or stopped providing abortion care, including all of the facilities in the Northern Plains, the Lower Rio Grande Valley, and southeast Texas, and all but one facility in West Texas. That amounts to a 46% decline in the number of facilities providing abortion care (Table 1 and Figure 1).

Table 1. Number of facilities providing abortion services on different dates b

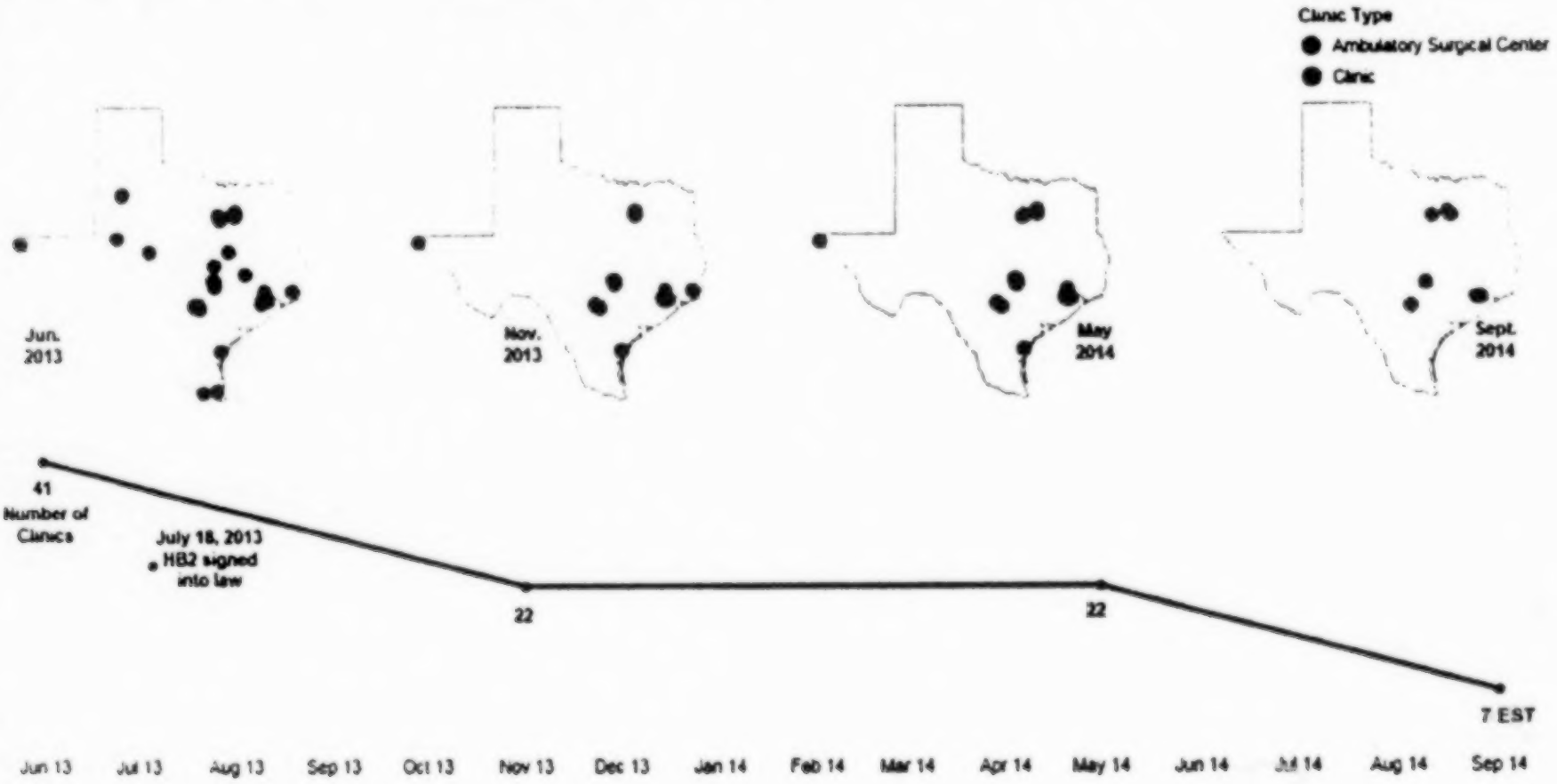
Location	Number		
	5/1/13	10/31/13	11/1/13
West Texas and Northern Plains (Health Regions 1/9/10)			
El Paso	2	2	1
Lubbock	1	1	0
Midland	1	0	0
San Angelo	1	0	0
Regional subtotal	5	3	1
North Texas (Regions 2/3/4)			
Dallas	5	5	3
Ft. Worth	3	3	0
Regional subtotal	8	8	3
Houston and East Texas (Regions 5/6)			
Beaumont	1	1	1
Houston	10	10	10
Stafford	1	0	0
Regional subtotal	12	11	11
Central Texas (Region 7)			
Austin	4	4	3
College Station	1	0	0
Killeen	1	1	0
Waco	1	0	0
Regional subtotal	7	5	3
San Antonio (Region 8)			
San Antonio	6	3	3
Regional subtotal	6	3	3

South Texas (Region 11)						
Corpus Christi	1	1	1	1	0	0
Harlingen	1	1	0	0	0	0
McAllen	1	1	0	0	0	0
Regional subtotal	3	3	1	1	0	0
Total	**41**	**33**	**22**	**22**	**20**	**7**

* Assumes that currently operating ASC's have physicians with admitting privileges at nearby hospitals.

^ Assumes that the new ASC announced by Planned Parenthood of Greater Texas will be operational by 9/1/14.

Figure 1. Decrease in Number of Licensed Facilities Providing Abortion Services from June 2013 to Sept. 2014



11 With respect to the Lower Rio Grande Valley, there had been two facilities providing abortion services there in November 2012—Reproductive Services of Harlingen and Whole Woman's Health in McAllen. My research determined that both of these facilities ceased providing abortion services during Period 3.

12. The decline in the number of facilities providing abortion services appears to be related to changes in State law—including the enactment of HB2, which imposes restrictions on the provision of abortion care, and a restructuring of the State's program for funding family planning services. But I am not here offering any opinion on the cause of the decline in the number of abortion facilities from November 2012 to April 2014. Instead, my testimony focuses on the impact of that decline, particularly with respect to women's ability to obtain legal abortion services in Texas, and how it enables us to forecast the impact of the ASC requirement.

13. As shown in Figure 2, DSHS assigns each Texas county to a health service "region." The abortion facility closures[1] resulted in a significant decrease in the number of abortions performed in Texas between Periods 1 and 3 across Texas's health service regions and four largest metropolitan areas.

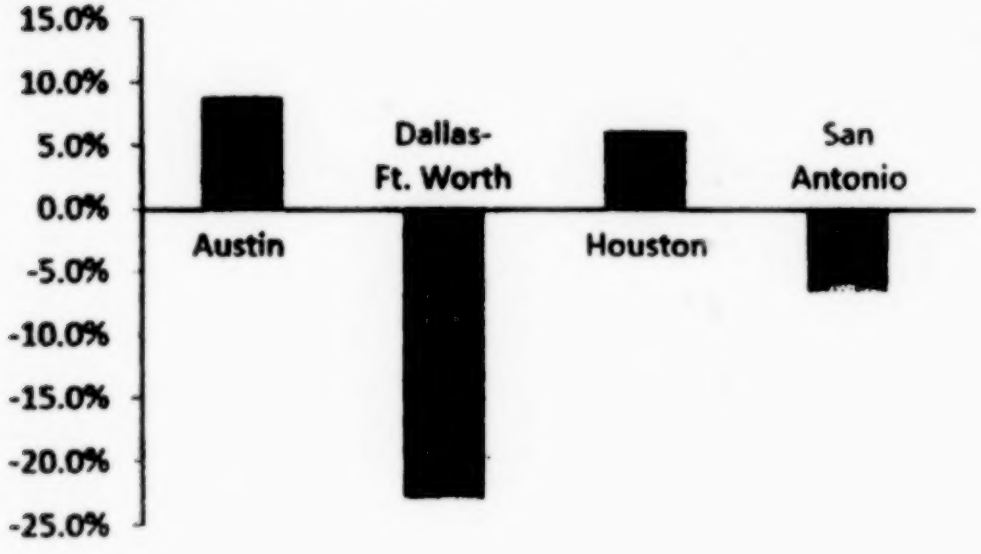
---

[1] From this point on, I will use the term "closure" to refer both to clinics that closed and clinics that remained open but ceased providing abortion services.

Figure 2. Texas Health Service Regions

14. The Northern Plains and West Texas (regions 1/9/10) were hardest hit, with a 65% decline in the total number of abortions performed there. North Texas (regions 2/3/4) had a decline of 23%, which was also greater than the state average. Other regions had declines that were less than the state average, and two regions had small increases. The number of abortions performed in Austin and Houston increased, while it decreased in Dallas-Fort Worth and San Antonio (see Figure 3).

Figure 3: Percent Change in total abortions performed in four metropolitan areas in Texas (Period 1 to Period 3)



15. Overall, the abortion rate in Texas declined 13% in Period 3 compared to Period 1 (the same 6-month period one year earlier), corresponding to about 9,200 fewer abortions each year (Table 2). This rate of decline is three times greater than the change in the national abortion rate, which declined by 13% over a three-year period between 2008 and 2011, or 4.3% per year.[2] For women living in the Lower Rio Grande Valley,[3] the number of abortions decreased by

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[2] Jones RK, Jerman J. Abortion incidence and service availability in the United States, 2011. Perspect Sex Reprod Health. 2014 Mar;46(1):3-14.

[3] The Lower Rio Grande Valley consists of the portion of region 11 comprised of Cameron, Hidalgo, Starr, and Willacy counties.

approximately 20% from Period 1 (1,349 abortions) to Period 3 (approximately 1,065 abortions), which appears to be a greater decline than for the state overall.

16. Abortions, like births, are known to have seasonal variation.[4] In Texas, more abortions are performed in months at the beginning of the year; the monthly number of abortions declines steadily until November and then increases in December. When comparing abortion rates in different years for a period of less than a full year, it is important to either compare data from the same months or otherwise control for seasonality.

---

[4] Weerasinghe DP, MacIntyre RC. Seasonality of births and abortions in New South Wales, Australia. Med Sci Monit. 2003 Dec;9(12):CR534-40: Parnell AM, Rodgers JL. Seasonality of induced abortion in North Carolina. J Biosoc Sci. 1998 Jul;30(3):321-32; Cesario SK. The "Christmas Effect" and other biometeorologic influences on childbearing and the health of women. J Obstet Gynecol Neonatal Nurs. 2002 Sep-Oct;31(5):526-35; Rojansky N, Brzezinski A, Schenker JG. Seasonality in human reproduction: an update. Hum Reprod. 1992 Jul;7(6):735-45.

Table 2. Abortions performed in Texas during three periods

	DSHS 2012 statewide statistics (12 months)	Period 1 (1 Nov 2012-30 Apr 2013)	Period 2 (1 May 2013-31 Oct 2013)	Period 3 (1 Nov 2013-30 Apr 2014)	% change from Period 1 to 3
Total number of abortions	68,298	35,415	32,611	30,800	-13.0%
Annualized abortion rate (per 1000 women age 15-44)	12.5	12.9	11.9	11.2	-13.0%
Number of early medical abortions	18,960 (27.8%)	9,948 (28.1%)	9,079 (27.8%)	2,991 (9.7%)[a]	-69.9%
Number of first-trimester surgical abortions (≤12 weeks)	42,017 (61.5%)	20,698 (58.4%)	19,343 (59.3%)	23,531 (76.4%)	13.7%
Number of second-trimester surgical abortions(≥12 weeks)	7,321 (10.7%)	4,768 (13.5%)	4,190 (12.8%)	4,278 (13.9%)[b]	-10.3%
Number of women living in Lower Rio Grande Valley[c] obtaining abortion	N/A[d]	1,349	1,304	1,065	-21.1%
Total number of abortions performed at an ambulatory surgical center	14,361 (21.0%)	9,378 (26.4%)	8,867 (27.2%)	6,786 (22.0%)	

[a] X^2 p-value<0.001 for medical abortion compared to surgical abortion <12 weeks for both Period 1 vs. Period 3 and Period 2 vs. Period 3

[b] X^2 p-value<0.001 for surgical abortion ≥12 weeks compared to surgical abortion <12 weeks for both Period 1 vs. Period 3 and Period 2 vs. Period 3

[c] Women reporting a residence in Starr, Hidalgo, Willacy or Cameron County

[d] Data not available for 2012. In 2011, 2,634 women living in the Lower Rio Grande Valley obtained an abortion.

17. Of those women from the Lower Rio Grande Valley who did receive abortions in Period 3, about half obtained abortions in Corpus Christi, about one-quarter obtained them in Houston, and 15% obtained them in San Antonio. Of note, the clinic providing abortion care in Corpus Christi closed in June 2014, after the period of this analysis.

18. The number of medical abortions declined by 70% in Period 3 compared to Period 1; only 9.7% of abortions in Texas in Period 3 were medical abortions, much lower than in the state vital statistics for 2012 (when 28% of all Texas occurrence abortions were early medical abortions). In contrast to our findings in Texas, the national trend is toward an increase in the proportion of abortions that are medical abortion, from 17% in 2008 to 23% in 2011.[5]

19. Notably, there was a small but significant increase in the proportion of abortions performed in the second trimester in Period 3 compared to Periods 1 and 2.

20. The number and proportion of abortions performed in ASCs decreased during the study. In Period 1, 9,378 abortions (26% of all abortions) were performed in ASCs, while in Period 3, 6,786 abortions (22% of all abortions) were performed in ASCs. In

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[5] Jones RK, Jerman J. Abortion incidence and service availability in the United States, 2011. Perspect Sex Reprod Health. 2014 Mar;46(1):3-14.

2012, 21% of all abortions were performed in ASCs.[6] Each of the ASCs except one in Houston (which reported no change in the number of abortions performed in Period 3) reported declines in the number of abortions performed in Period 3 that were greater than the state average, ranging from a 17% decrease to a 62% decrease. These decreases occurred despite increasing demand for abortion in the cities in which these ASCs were located, as indicated by the fact that some of the other clinics in those cities reported an increase in the number of abortions performed. The decrease at the ASCs is likely indicative of their inability to increase capacity in the face of growing demand. This may be a result of the admitting privileges requirement, which limits physician staffing, or facility limitations. My opinion is that these existing ASCs as a group will not be able to go from providing approximately 14,000 abortions annually, as they currently are, to providing the 60,000 to 70,000 abortions that are done each year in Texas once all of the non-ASC clinics are forced to close.

21. Due to the facility closures, women now face longer travel distances to reach an abortion clinic. The number of women of reproductive age in Texas living in a county more than 50 miles from a clinic providing abortion in Texas increased from 816,000 in Period 1 to 1,680,000 at the end of Period 3 (Figure

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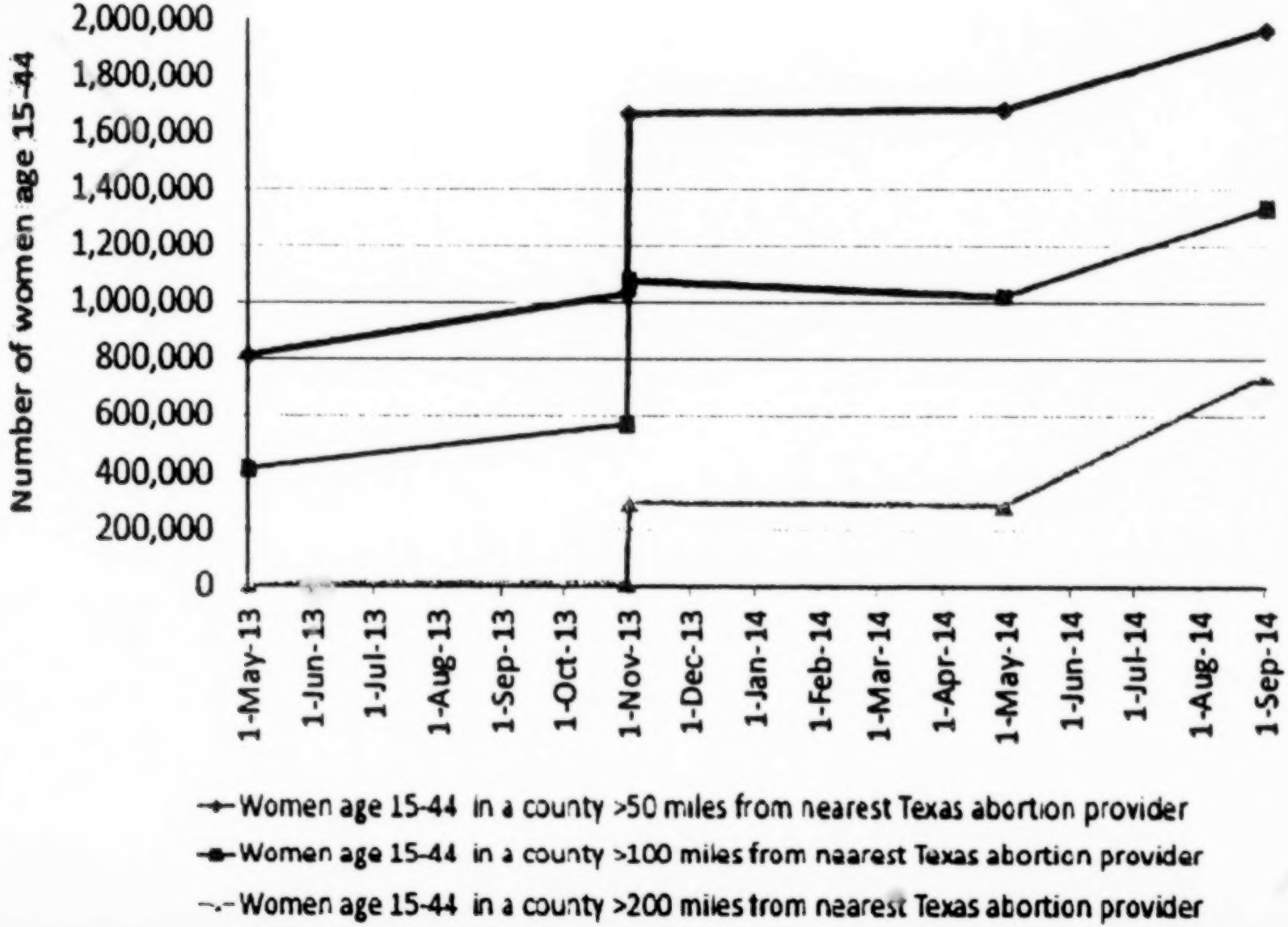
[6] The data on 2012 Texas occurrence abortions were obtained from a request to the Texas Department of State Health Services.

4). The number of women of reproductive age in Texas living in a county more than 100 miles from a clinic providing abortion in Texas increased from 417,000 in Period 1 to 1,020,000 at the end of Period 3. The number of women of reproductive age in Texas living in a county more than 150 miles from a clinic providing abortion in Texas increased from 86,000 in Period 1 to 400,000 at the end of Period 3. The number of women of reproductive age in Texas living more than 200 miles from a clinic providing abortion in Texas increased from 10,000 in Period 1 to 290,000 at the end of Period 3.

Figure 4. Number of women age 15-44 living in a county at various distances from the nearest Texas abortion provider on various dates



22. The data described above provide strong evidence that the abortion facility closures have had a significant negative impact on women's ability to obtain abortion services in Texas. In my opinion, the best explanation for the decline in the Texas abortion rate and the decline of the abortion rate for women living in the Lower Rio Grande Valley—both of which are greater declines than the national average—is that some women who would have otherwise obtained abortion care were unable to negotiate the increased costs and travel distances that resulted from abortion facility closures.[7]

23. The ASC requirement, which goes into effect on September 1, 2014, will increase the impact observed in this study substantially by resulting in a

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[7] An alternative hypothesis to explain the declining abortion rate is improved contraceptive use—especially use of long-acting reversible contraceptive (LARC) methods. This seems particularly unlikely in Texas given the severe reduction in public family planning funding that the Texas legislature imposed in 2011. Although the legislature restored most of the funding for family planning services in 2013, many organizations that served low-income women had not yet received these funds by the end of 2013. In addition, data from the Centers for Disease Control and Prevention (CDC) indicate an increase in births to women in Texas between 2012 and 2013, although the data for the later year are not yet final. Martin JA, Hamilton BE, Osterman JK, et al. Births: Final data for 2012. National vital statistics reports; vol 62 no 9. Hyattsville, MD: National Center for Health Statistics. 2013; Hamilton BE, Martin JA, Osterman MJK, Curtin SC. Births: Preliminary data for 2013. National vital statistics reports web release; vol 63 no 02. Hyattsville, MD: National Center for Health Statistics. 2014.

greater number of clinic closures. Based on the information that the Texas Policy Evaluation Project gathered from the Texas Department of State Health Services, interviews with abortion facility staff members, and reports in the press, it appears that the only remaining ASCs providing abortion care will be located in Texas's four largest metropolitan areas: Dallas-Fort Worth, Houston, San Antonio, and Austin. There will be no abortion facilities remaining south or west of San Antonio. This will significantly increase distances that women in South and West Texas must travel to obtain abortion services. The number of women of reproductive age in Texas living more than 50 miles from a clinic providing abortion in Texas will increase to 1,960,000, which is a 140% increase compared to May 2013. The number of women of reproductive age in Texas living more than 100 miles from a clinic providing abortion in Texas will increase to 1,335,000 when the ASC requirement goes into effect (a 220% increase compared to May 2013). The number of women of reproductive age in Texas living more than 150 miles from a clinic providing abortion in Texas will increase to 930,000 when the ASC requirement goes into effect (a 980% increase compared to May 2013). The number of women of reproductive age in Texas living more than 200 miles from a clinic providing abortion in Texas will increase to 752,000 when the ASC requirement goes into effect (a 7400% increase compared to May 2013). These distances are much greater than the national mean distance traveled to an abortion clinic, which

was 30 miles in 2008; only 6% of abortion patients traveled more than 100 miles.[8]

24. I understand that the Defendants' expert, Todd Giberson, estimates the number of Texas women of reproductive age women who will live more than 150 miles from a Texas abortion provider on September 1, 2014 to be 891,888. Even if we rely on his calculation, it would still be a very large number of Texas women who would have to travel over 150 miles to access legal abortion care. To put this number in context, consider that half of all states and the District of Columbia have a total population of reproductive age women that is less than 891,888 (Table 2).

[8] Jones RK, Jerman J. How far did US women travel for abortion services in 2008? J Women's Health (Larchmt). 2013 Aug;22(8):706-13.

Table 2. Number of Reproductive-Age Women (Age 15-44) in U.S. States and the District of Columbia

California	7,876,871
Texas	5,326,162
New York	4,047,947
Florida	3,560,982
Illinois	2,631,753
Pennsylvania	2,442,538
Ohio	2,235,171
Georgia	2,073,006
North Carolina	1,949,350
Michigan	1,918,594
New Jersey	1,738,419
Virginia	1,652,698
Washington	1,355,704
Massachusetts	1,350,576
Arizona	1,287,393
Tennessee	1,274,350
Indiana	1,262,557
Maryland	1,193,402
Missouri	1,176,684
Wisconsin	1,097,595
Minnesota	1,045,681

Colorado	1,025,085
Alabama	960,620
Louisiana	928,335
South Carolina	928,310
Texas Women More Than 150 Miles From Texas Abortion Provider Per State Defendants	891,888
Kentucky	854,846
Oregon	754,077
Oklahoma	736,629
Connecticut	691,265
Utah	604,036
Mississippi	602,120
Iowa	576,692
Arkansas	569,446
Nevada	554,584
Kansas	549,924
New Mexico	398,587
Nebraska	355,031
West Virginia	341,981
Idaho	306,303
Hawaii	262,107

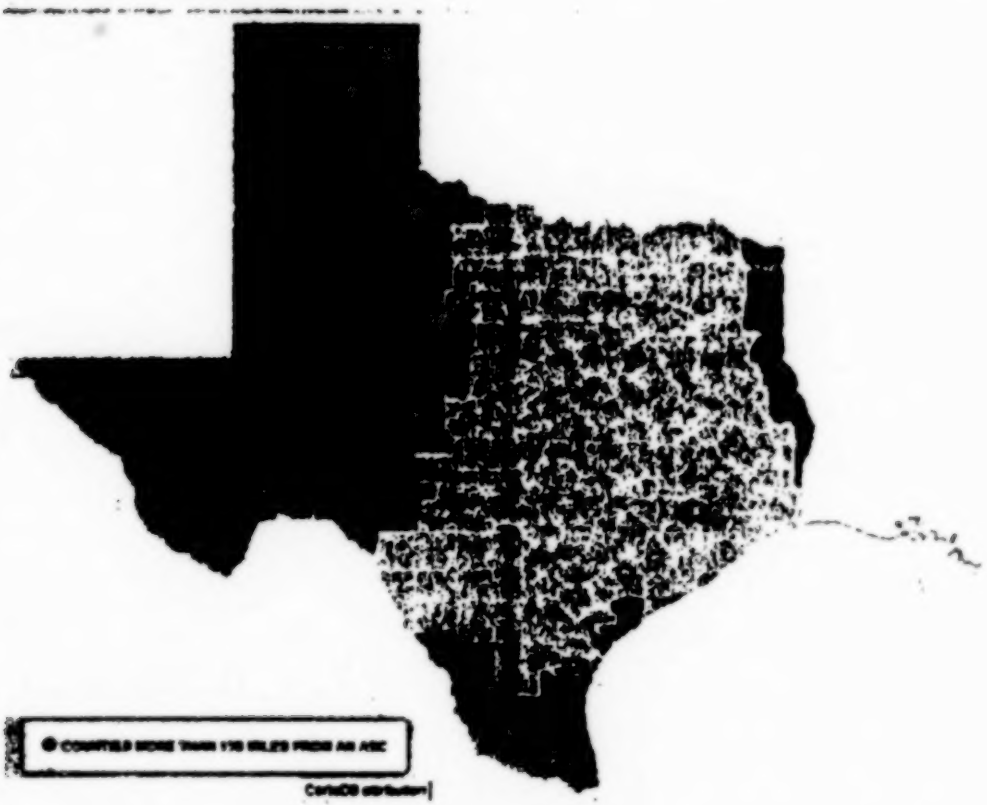
New Hampshire	250,133
Maine	241,923
Rhode Island	214,647
Montana	179,670
Delaware	179,232
District of Columbia	162,314
South Dakota	152,353
Alaska	143,229
North Dakota	129,143
Vermont	118,297
Wyoming	106,612

Source: U.S. Census Bureau Summary File 1, Table P12

Amended Rebuttal Report of Todd Giberson, dated July 11, 2014

25. Further, the counties in Texas that are more than 150 miles from the nearest abortion provider will occupy an area that is substantially larger than the State of Mississippi (Figure 3).

Figure 3. Texas Counties More Than 150 Miles from a Texas Abortion Provider as of September 1, 2014



26. We did not collect data on the number of women traveling out of state for abortion services. It is unlikely that women in the Rio Grande Valley would have traveled out of state because doing so would have entailed even greater travel distances than traveling to San Antonio, Austin, or Houston. And abortion is legally restricted everywhere in Mexico except Mexico City, which is over 600 miles from the Rio Grande Valley. For women in many other parts of Texas, the availability of out-of-state abortion services is likely to decrease because neighboring states Oklahoma and Louisiana have recently

enacted admitting privileges requirements that are about to take effect.

27. Increased travel distances have been shown to cause some women to delay receiving abortion care or forego it altogether.[9] Our analysis found a relative increase in second-trimester abortion during the same time period as the clinic closures. Although this increase is small in magnitude, it nonetheless means that a larger proportion of women faced the higher risk of complications associated with later abortion, as well as its higher cost.[10] The findings from this study are consistent with the findings of earlier studies that increased travel distance causes a delay in receiving abortion care.[11]

28. They are also consistent with Texas' experience following the 2003 enactment of a law limiting

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[9] Colman S, Joyce T. Regulating Abortion: Impact on Patients and Providers in Texas. Journal of Policy Analysis and Management 2011;30:775-97 (P-152); Upadhyay UD, Weitz TA, Jones RK, Barar RE, Foster DG. Denial of Abortion Because of Provider Gestational Age Limits in the United States. Am J Public Health 2013 (P-156)

[10] Bartlett LA, Berg CJ, Shulman HB, Zane SB, Green CA, Whitehead S, Atrash HK. Risk factors for legal induced abortion-related mortality in the United States. Obstet Gynecol. 2004 Apr;103(4):729-37 (P-098); Jones RK, Kooistra K. Abortion incidence and access to services in the United States, 2008. Perspect Sex Reprod Health. 2011 Mar;43(1):41-50.

[11] Dobie SA, Hart LG, Glusker A, Madigan D, Larson EH, Rosenblatt RA. Abortion services in rural Washington State, 1983-1984 to 1993-1994: availability and outcomes. Fam Plann Perspect. 1999 Sep-Oct;31 (5):241-5.

the performance of abortions at 16 weeks or later to ASCs and hospitals. A detailed study by economists found that, when the law took effect, there was an immediate and dramatic reduction in both the number of licensed facilities in Texas able to provide abortion services at 16 weeks and later and in the number of abortions performed in Texas at those gestational ages.[12] Two years later, the abortion rate for those gestational ages remained 50% below what it was prior to the law's enactment.

Expected Rise in Attempted Self-Induction of Abortion

29. I have been the lead investigator on several recent studies concerning self-induction of abortion. The term "self-induction" generally refers to attempts by a woman to terminate her own pregnancy without seeking treatment from a licensed medical professional. My research and the research of others has found that a variety of methods are used to self-induce abortion in the United States. Invasive intravaginal techniques appear to be rare, but they are still used by some women.[13] More commonly drugs

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[12] Colman S, Joyce T. Regulating Abortion: Impact on Patients and Providers in Texas. Journal of Policy Analysis and Management 2011;30:775-97 (P-152).

[13] Grossman D, Holt K, Pena M, Lara D, Veatch M, Cordova D, Gold M, Winikoff B, Blanchard K. Self-induction of abortion among women in the United States. Reproductive Health Matters 2010;18(36): 136-146 (P-160); Saultes TA, Devita D,

(Continued on following page)

such as misoprostol, which is a prostaglandin analogue, vitamin C, aspirin, laxatives, or hormonal preparations are used, as are herbs, certain foods, alcohol or drugs.[14] Women have also reported intentionally falling down stairs or getting beaten in the abdomen to cause an abortion.[15] Other than misoprostol, most of these methods are generally not effective to induce an abortion.

30. Misoprostol is widely available in Mexico and other parts of Latin America. It is commonly trafficked across the Texas-Mexico border and sold on the black-market, including at Texas flea markets and over the internet.

31. In a nationally representative study of US abortion patients conducted in 2008-2009, 1.2% of participants reported having used misoprostol to try to induce an abortion, and 1.4% reported having ever

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Heiner JD. The back alley revisited: sepsis after attempted self-induced abortion. West J Emerg Med. 2009 Nov;10(4):278-80.

[14] Jones RK. How commonly do US abortion patients report attempts to self-induce? Am J Obstet Gynecol 2011;204:23.e1-4; Grossman D, Holt K, Pena M, Lara D, Veatch M, Cordova D, Gold M, Winikoff B, Blanchard K. Self-induction of abortion among women in the United States. Reproductive Health Matters 2010;18(36): 136-146 (P-160).

[15] Grossman D, Holt K, Pena M, Lara D, Veatch M, Cordova D, Gold M, Winikoff B, Blanchard K. Self-induction of abortion among women in the United States. Reproductive Health Matters 2010;18(36): 136-146 (P-160).

used other methods to try to induce an abortion.[16] Only 0.8% reported taking misoprostol in the current pregnancy. In that study, foreign-born women were significantly more likely to report attempting abortion self-induction. In a non-representative study conducted in Boston, New York City, San Francisco, and McAllen, TX, 4.6% of ever-pregnant women surveyed in low-income clinics reported attempting self-induction at some point in the past.[17]

32. In October-December 2012, colleagues and I conducted a survey with 318 abortion patients at 8 clinics in 6 cities across Texas and included several questions about abortion self-induction.[18] Overall, 7% of women reported taking steps prior to coming to the clinic to try to end the pregnancy on their own. At clinics in McAllen and El Paso, about 12% reported attempting self-induction in the current pregnancy. These proportions are much higher than those reported in the only nationally representative study, suggesting that self-induction is more common in Texas, particularly in locations close to the Texas-Mexico border.

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[16] Jones RK. How commonly do US abortion patients report attempts to self-induce? Am J Obstet Gynecol 2011;204:23.e1-4.

[17] Grossman D, Holt K, Pena M, Lara D, Veatch M, Cordova D, Gold M, Winikoff B, Blanchard K. Self-induction of abortion among women in the United States. Reproductive Health Matters 2010;18(36): 136-146 (P-160).

[18] Grossman D, White K, Hopkins K, Potter JE. The public health threat of anti-abortion legislation. Contraception 2014;89:73-4.

33. There are a variety of health risks associated with abortion self-induction. Traumatic methods using intravaginal or external manipulation can obviously be quite dangerous. Depending on the medication and dosage used, some medications may also be dangerous. Misoprostol in correct dosages is one of the safest methods that can be used to self-induce abortion. However, especially if it is used later in pregnancy, there is a higher risk of hemorrhage, and if high doses are used in women with a history of cesarean delivery, there is a risk of uterine rupture.[19]

34. Although women report a variety of reasons for attempting self-induction, one of the most common reasons is lack of local access to clinical abortion care.[20] In other words, often, when women attempt self-abortion, it is because they are unable to access care from licensed abortion providers—typically because of distance or legal restrictions such as gestational limits and parental consent laws. Another reason sometimes reported is lack of access to a women's preferred method of abortion (meaning that a woman would like to have a medical abortion but only surgical abortion is available).

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[19] Ashok PW, Templeton A, Wagaarachchi PT, Flett GM. Midtrimester medical termination of pregnancy: a review of 1002 consecutive cases. Contraception 2004;69(1):51-8.

[20] Grossman D, Holt K, Pena M, Lara D, Veatch M, Cordova D, Gold M, Winikoff B, Blanchard K. Self-induction of abortion among women in the United States. Reproductive Health Matters 2010;18(36): 136-146 (P-160).

35. As abortion access in Texas becomes more limited, I expect that self-induction will become more prevalent in the state, particularly in places like the Lower Rio Grande Valley, where all of the clinics providing abortion care closed, there is a significant population of immigrants from Latin America with knowledge of methods of self-induction, and there is relatively easy access to misoprostol across the border in Mexico.

Safety of Abortion and Complications at an ASC versus non-ASC clinic

36. Legal abortion is one of the safest medical procedures in the United States, and it is quite common. Approximately 3 in 10 women will obtain an abortion by the age of 45.[21]

37. Over 90% of all abortions performed in the United States are performed in an outpatient setting.[22] Complications associated with abortion are not common, and almost all of the complications associated with abortion prior to 16 weeks of pregnancy post-fertilization, can be safely and appropriately managed in an outpatient, clinic setting.

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[21] Jones RK & Kavanaugh M. Changes in abortion rates between 2000 and 2008 and lifetime incidence of abortion. Obstet & Gynecol. 2011;117:1358.

[22] Jones RK, Jerman J. Abortion incidence and service availability in the United States, 2011. Perspect Sex Reprod Health. 2014 Mar;46(1):3-14.

38. In terms of risks, rate of complication, and duration of the procedure, surgical abortion is comparable to other procedures routinely performed in a physician's office, such as dilation and curettage (D&C) for gynecological diagnosis and/or treatment of miscarriage, diagnostic hysteroscopy (to visualize the inside of the uterus), endometrial biopsy (to take a small tissue sample from the uterine lining), or vasectomy. In fact, performing a surgical abortion by suction aspiration is basically the same procedure as performing a D&C for a patient with a miscarriage. By way of comparison, vasectomy is reported to have a prevalence of complications of 2% and a prevalence of major complications requiring hospitalization of 0.2% to 0.8%, depending on the surgeon's experience.[23]

39. A recent large study found that the prevalence of any complication of first-trimester surgical abortion performed by physicians in an outpatient setting was 0.89%, and the prevalence of major complications requiring treatment at a hospital was 0.05%.[24] Another recent study found that the risk of an adverse event associated with outpatient abortions performed up to 16 weeks post-fertilization was 0.3%,

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[23] Adams CE, Wald M. Risks and complications of vasectomy. Urol Clin North Am. 2009 Aug;36(3):331-6.

[24] Weitz TA, Taylor D, Desai S, et al. Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives, and physician assistants under a California legal waiver. Am J Public Health 2013;103:454-61.

and the risk of an adverse event requiring hospitalization was 0.07%.[25] In another retrospective cohort study, the prevalence of major immediate complications (defined as uterine perforation or hospital transfer) was 0.3% at 10-13 weeks postfertilization and 0.7% at 14-16 weeks post-fertilization.[26]

40. Almost all of the complications associated with abortion before 16 weeks postfertilization, can be appropriately and safely managed in the clinic setting. For example, most cases of hemorrhage are managed in the clinic setting with uterotonics, medications that increase the tone of uterine contractions and reduce bleeding. Likewise, most cases of cervical laceration are managed in the clinic setting with either cauterizing medications or by suturing the laceration. And cases of incomplete abortion are generally managed in the clinic through repeat aspiration and medications.

41. As noted above, major complications of abortion before 16 weeks performed in a clinic are rare. These rare complications include severe hemorrhage not responsive to medical management or re-evacuation of the uterus; uterine perforation; or

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[25] Wilson LC, Chen BA, Creinin MD, Low-dose fentanyl and midazolam in outpatient surgical abortion up to 18 weeks of gestation. Contraception 2009;79(2): 122-28.

[26] Racek CM, Chen BA, Creinin MD, Complication rates and utility of intravenous access for surgical abortion procedures from 12 to 18 weeks of gestation. Contraception 2010;82: 286-290.

severe complications related to anesthesia, such as a seizure or aspiration. Patients undergoing these complications must be transferred to a hospital for appropriate management, which might include blood transfusion, uterine artery embolization, or major abdominal surgery such as hysterectomy. This kind of treatment is not generally available at an ambulatory surgical center (ASC). Therefore, I would not expect that the overall risk of major complications requiring hospitalization would differ between abortions performed at a non-ASC clinic and abortions performed at an ASC for the same gestational age period.

42. Nor do I expect that the heightened construction and staffing requirements for ASCs would lead to a reduction in major complications of abortion. The heightened construction requirements are largely aimed at maintaining a sterile operating environment. These requirements enhance the safety of surgeries that involve cutting into sterile body tissue by reducing the likelihood of infection. But surgical abortion is not performed in this manner. Rather, it entails insertion of instruments into the uterus through the vagina, which is naturally colonized by bacteria. Accordingly, precautions aimed at maintaining a sterile environment, beyond basic handwashing and use of sterile instruments, provide no health or safety benefit to abortion patients. Similarly, the heightened staffing requirements for ASCs are geared toward surgeries that are more complex that abortion. Many of the personnel typically needed for those types of surgeries, such as scrub nurses or technicians

and circulating nurses, are not needed for abortion procedures.

43. In order to explore the prevalence of complications at ASCs compared to non-ASC clinics, I reviewed complications of abortions performed at less than 16 weeks actual gestation at the ASC in San Antonio currently operated by Whole Woman's Health and three non-ASC clinics currently operated by Whole Woman's Health.

44. The ASC opened in August 2010; therefore the period of this analysis was between August 2010 and April 2014. With assistance from a colleague at Ibis Reproductive Health, I reviewed clinic logs and worked with clinic staff to determine the total number of abortions before 16 weeks performed at each clinic during this period. These clinics also maintain complication logs where all hospital transfers are recorded, as well as any delayed complication that is reported by a patient at the time of a follow-up visit or telephone call. I reviewed these logs to identify major complications, defined as those that required hospitalization, abdominal surgery (including laparoscopy), intravenous antibiotics or blood transfusion. Death is also considered a major complication, but there were no abortion-related deaths during this period in Texas. In the case of a hospital transfer for bleeding, if no details of the treatment were available, I assumed it was a major complication.

45. During this period, a total of 2,980 abortions before 16 weeks were performed at the ASC, while

17,628 abortions were performed at the three non-ASC clinics. There were five major complications at the non-ASC clinics. During this same period there were five major complications at the ASC. The proportion of abortions before 16 weeks with a major complication at the non-ASC clinics was 0.028% (95% confidence interval 0.004%-0.053%), while this proportion was 0.17% (95% confidence interval 0.021%-0.315%) for the ASC. The difference between the proportion of abortions with a major complication is statistically significantly different, with the non-ASC clinics having a significantly lower proportion of major complications (p=0.008, Fisher's exact test).

46. Of note, six of the ten major complications occurred in 2011. Between January 1, 2012, and April 30, 2014, we identified only one major complication at the ASC (among 1,938 abortions before 16 weeks, or 0.05%) and three major complications at the non-ASC clinics (among 11,616 abortions before 16 weeks, or 0.03%).

47. These proportions are low for both the non-ASC clinics and the ASC, and they are consistent with the literature. The slightly higher major complication proportion for the ASC facility may be because higher risk patients (such as obese women or those with a prior cesarean delivery) are more likely to have their procedure done at an ASC. Women may also be more likely to have deeper sedation at an ASC, and deep sedation confers more risk than moderate or less sedation, which may be used at a non-ASC clinic. Unfortunately, we were not able to control

for these factors in the analysis. But the findings show that, under real-world conditions, as abortion is currently performed in Texas, major complications are not less prevalent in ASCs than in non-ASCs.

48. Overall, these findings reflect the safety of abortion performed in non-ASC clinics. There is no indication from this analysis that the risk of major complications is reduced when abortion is performed in an ASC or that patients who would otherwise choose to have an abortion in a clinic would derive any health benefit from having the procedure in an ASC instead.

Dated: August 3, 2014

Austin, Texas

By: /s/ D Grossman
Daniel Grossman, M.D.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH; *et al.*,	)	
Plaintiffs,	)	CIVIL ACTION
v.	)	CASE NO. 14-CV-284-LY
DAVID LAKEY, M.D.; *et al.*,	)	
Defendants.	)	

DIRECT TESTIMONY OF
ELIZABETH GRAY RAYMOND, M.D., M.P.H.

(Filed Aug. 4, 2014)

ELIZABETH GRAY RAYMOND, M.D., M.P.H, under penalty of perjury, testifies as follows:

1. I am an obstetrician-gynecologist and medical researcher. I currently serve as a Senior Medical Associate at Gynuity Health Projects, and I have an appointment as Adjunct Professor in the Obstetrics and Gynecology Department at New York University School of Medicine.

2. I received an M.D. degree from Columbia University College of Physicians and Surgeons in 1984 and then completed a residency in obstetrics and gynecology at Duke University Medical Center. I received a Master of Public Health degree from Johns Hopkins University in 1991.

3. I worked for several years as an epidemiology fellow at the National Institutes of Health, where my work focused on maternal and child health. Subsequently, I joined the staff of Family Health International, where I spent 16 years conducting clinical, behavioral, and programmatic research about reproductive health issues. I joined the staff of Gynuity Health Projects in 2010. My responsibilities there include designing, managing, and providing technical assistance to research projects concerning reproductive health technologies.

4. I have not been engaged in clinical practice since joining Gynuity Health Projects, but in the past, I have served as a staff physician in the Obstetrics and Gynecology Department at Tuba City Indian Medical Center in Tuba City, Arizona; the Department of Surgery at the Veterans Administration Medical Center in Durham, North Carolina; and two Planned Parenthood-affiliated outpatient clinics in North Carolina. My clinical practice encompassed a broad range of ob-gyn services including family planning, pregnancy-related care, gynecological surgery, cancer screening, and abortion services.

5. I have written or co-authored more than 60 publications in peer-reviewed journals, as well as at least 32 other publications including editorials, commentaries, and book chapters. My curriculum vitae, which sets forth my experience and credentials more fully, is annexed hereto as P-003. It contains a complete list of the publications that I have authored or co-authored during my career.

6. I am testifying as an expert in the fields of obstetrics and gynecology, reproductive health, and public health. My opinions are based on my research, writing, and teaching about these subjects, as well as my past experience as an ob-gyn.

Introduction

7. I am familiar with the requirements of Texas House Bill No. 2 (HB2), including the "admitting privileges requirement," which mandates that all physicians who provide abortion services "have active admitting privileges at a hospital that . . . is located not further than 30 miles from the location at which the abortion is performed or induced," and the "ASC requirement," which mandates that "the minimum standards for an abortion facility must be equivalent to the minimum standards . . for ambulatory surgical centers" under Texas law.

8. Evidence-based medicine is standard practice in healthcare today. It requires that clinicians and others making decisions about healthcare rely on current, relevant, and valid data about the effects of proposed interventions on the wellbeing of the people who may be affected by them.

9. For the reasons explained below, the admitting privileges and ASC requirements are inconsistent with the principles of evidence-based medicine. No data show that these requirements will enhance the health or safety of women seeking abortion services. Rather, evidence demonstrates that these

requirements will put women at greater risk of negative health outcomes by causing them to delay desired abortion procedures, forgo desired abortion procedures, seek illegal abortion procedures, or attempt to self-induce abortion.

Overview of Legal Induced Abortion in the United States

10. Most legal induced abortions in the United States are provided in outpatient facilities rather than in hospitals. In Texas, for example, at least 99.6% of all abortions in 2010 were performed as outpatient procedures. Of those, 87% were performed in abortion clinics or physicians' offices rather than in ambulatory surgical centers (ASCs). (Data from the Texas Department of State Health Services ("DSHS"), http://www.dshs.state.tx.usichs/vstat/vs10/t38.shtm, accessed 13 June 2014.)

11. Two procedures are currently used in the United States to provide abortion in outpatient facilities: surgical abortion, which is the use of medical instruments to evacuate the contents of the uterus, and medical abortion, which is the administration of medications that result in termination of a pregnancy.

Mortality of Legal Induced Abortion in the United States

12. Abortion as currently practiced in the United States is very safe. The abortion-related

mortality rate in the United States over the decade 2000 to 2009, the latest year in which national data are available, was 0.69 deaths per 100,000 legal abortions. I calculated this figure by dividing the number of legal abortion-related deaths from the 50 states and Washington, DC, during those years (85) by the number of legal abortions occurring in the same time period (12,367,100).

13. I obtained the number of deaths from statistics published by the Centers for Disease Control and Prevention (CDC). CDC defines an abortion-related death as any death that is either: (a) a direct complication of an abortion, (b) an indirect complication caused by the chain of events initiated by the abortion, or (c) an aggravation of a preexisting condition by the physiologic or psychologic effects of the abortion, regardless of the amount of time between the abortion and the death.[1] CDC obtains information about abortion-related deaths by actively monitoring state vital records, media reports, legal cases, and the medical literature and by evaluating reports submitted by public health agencies, maternal mortality review committees, health-care providers and provider organizations, private citizens and citizen groups. For each death that possibly is related to abortion, CDC requests clinical records and autopsy reports. Two medical epidemiologists review these reports to

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[1] Bartlett LA, Berg CJ, Shulman HB, et al. Risk factors for legal induced abortion-related mortality in the United States. Obstet Gynecol 2004;103:729-37 (P-098).

determine the cause of death and whether the death was abortion related. Each death is categorized by abortion type as legal induced, illegal induced, spontaneous, or unknown type.[2]

14. I obtained the number of legal abortions from a report published by researchers at the Guttmacher Institute, which conducts periodic surveys of all known abortion providers in the United States.[3] The Guttmacher Institute supplements the data from this survey with information from health department agencies in 45 states and Washington, DC.

15. The mortality risk from legal induced abortion in the United States has declined since the *Roe v. Wade* decision in 1973. In 1973-1979, CDC estimated it as 2.09 deaths per 100,000 procedures. *See* Fn. 2. The risk subsequently dropped and has been stable at about the current rate for the past 30 years.

16. Legal induced abortion is safer the earlier the procedure is done. In 1988-1997, the latest interval for which national statistics on abortion-related deaths by gestational age have been published, the mortality rate among women who had abortions in

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[2] Pazol K, Creanga AA, Burley KD, Hayes B, Jamieson DJ. Abortion surveillance—United States, 2010. MMWR Surveill Summ 2013;62:1-44 (P-167).

[3] Jones RK, Jerman J. Abortion Incidence and Service Availability In the United States, 2011. Perspect Sex Reprod Health 2014.

the first trimester, which is when over 90% of abortions in the United States are performed,[2] was less than 0.4 deaths per 100,000 procedures. *See* Fns. 1 & 2. At gestational ages less than 8 weeks, which comprise 66% of abortions, it was 0.1 deaths per 100,000 procedures. Given the stability in the overall abortion-related mortality rate, I believe that the rates for these gestational age intervals in more recent years are likely to be similar.

Morbidity of Legal Induced Abortion in the United States

17. National statistics on non-fatal complications of abortion are not routinely collected. However, reliable data on abortion-related morbidity are available from numerous reliable studies, described below. These studies were conducted independently of one another by different researchers at different times using patient data from different sources. The consistency in their findings provides a basis for confidence in the reliability of their results.

18. Serious non-fatal complications of induced abortion as currently performed in outpatient facilities in the United States are extremely rare. A recent analysis performed by researchers from the University of California at San Francisco examined complications occurring within 6 weeks after 54,911 abortions that had been paid for by the fee-for-service California Medicaid program ("Medi-Cal") in 2009-2010. The

results are not yet published but have been presented at scientific meetings.

19. Almost all (97%) of these procedures were performed in outpatient settings. The incidence of abortion-related complications, including both major and minor events, was 2.1%. These complications included hemorrhage, infection, surgical trauma such as uterine perforation, anesthesia complications, incomplete abortion, continuing pregnancy (which is not actually a complication but rather a treatment failure), and other unclassified conditions. The incidence of major complications, defined as hospital admission, abdominal surgery, hysterectomy, or blood transfusion, was 0.23%. The study found that 6.4% of abortions were followed by a visit to an emergency department (ED), but most of these visits were for reasons unrelated to the abortion; only 0.87% of all abortions resulted in an ED visit at which treatment was provided for an abortion-related condition. Few of these visits occurred on the day of the abortion, and immediate transfer by ambulance was extremely rare, occurring after only 15 of the 54,911 total abortions (0.03%).

20. This study is notable because follow-up over the 6-week interval was likely to be essentially complete, particularly for complications that were diagnosed or treated outside the facility that provided the abortion, and because records of all complications were reviewed by clinically trained researchers.

21. The table below shows reported results of other recent studies of first and second trimester abortions performed in outpatient facilities in the United States.[4] Across these studies, the specific types of medical events that were considered to be complications varied: for example, some included innocuous events that were treated at the abortion clinic, whereas others included only more significant events. "Major complications" in most studies was defined to include hospitalizations, abdominal surgeries, transfusions, or deaths that were related to the abortion procedure, although some also counted treatments in

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[4] Bennett IM, Baylson M, Kalkstein K, Gillespie G, Bellamy SL, Fleischman J. Early abortion in family medicine: clinical outcomes. Ann Fam Med 2009;7:527-33; Weitz TA, Taylor D, Desai S, et al. Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives, and physician assistants under a California legal waiver. Am J Public Health 2013; 103:454-61; Paul ME, Mitchell CM, Rogers AJ, Fox MC, Lackie EG. Early surgical abortion: efficacy and safety. Am J Obstet Gynecol 2002;187:407-11; Goldman MB, Occhiuto JS, Peterson LE, Zapka JG, Palmer RH. Physician assistants as providers of surgically induced abortion services. Am J Public Health 2004;94:1352-7; Cleland K, Creinin MD, Nucatola D, Nshom M, Trussell J. Significant adverse events and outcomes after medical abortion. Obstet Gynecol 2013;121:166-71; Patel A, Talmont E, Morfesis J, et al. Adequacy and safety of buccal misoprostol for cervical preparation prior to termination of second-trimester pregnancy. Contraception 2006;73:420-30; Maurer KA, Jacobson JC, Turok DK. Same-day cervical preparation with misoprostol prior to second trimester D&E: a case series. Contraception 2013;88:116-21.

an ED[5] or other clinically significant events[6] as major complications. Despite the varied study populations and the definitional differences, the clear message of these data is that complications of induced abortion, and particularly complications that cannot be managed at the original abortion facility, are rare.

Table 1. Recent studies of outpatient abortion in the United States

	Types of abortions	Enrolled	Complications	
			All	Major
UCSF Medi-Cal study	Surgical and medical abortions covered by Medi-Cal fee-for-service, 2009-2010	54,911	2.1%	0.23%
Bennett[4]	1st trimester surgical and medical abortions at several sites in PA and NY, 2001-2005	2,458	3.5%	

[5] Cleland K, Creinin MD, Nucatola D, Nshom M, Trussell J. Significant adverse events and outcomes after medical abortion. Obstet Gynecol 2013;121:166-71.

[6] Patel A, Talmont E, Morfesis J, et al. Adequacy and safety of buccal misoprostol for cervical preparation prior to termination of second-trimester pregnancy. Contraception 2006;73:420-30.

Weitz[5]	1st trimester surgical abortions at 22 CA clinics, 2006-2011	11,487	1.3%	0.05%
Paul[6]	Early 1st trimester surgical abortions at 3 MA PP clinics, 1998-2000	1,132	2.7%	
Goldman[7]	Surgical abortions at 2 clinics in NH and VT, 1996-1997	1,363	2.3%	
Cleland[8]	1st trimester medical abortions at all PP clinics, 2009-2010	233,805	0.7%	0.16%
Patel[9]	2nd trimester surgical abortions at 19 PP affiliates, 2002-2003	2,218	1.9%	0.45%
Maurer[10]	2nd trimester surgical abortions at 1 UT clinic, 2001-2010	1,177	1.8%	

PP: Planned Parenthood

Empty cells indicate data not available.

22. The largest study of complications of outpatient abortion of which I am aware is not included in the above table because it was conducted several decades ago.[7] It included 170,000 first trimester surgical abortions performed at the three clinics of Planned Parenthood of New York City in 1971-1987. The researchers had follow-up on 92% of the patients. The overall complication rate was 0.9%; 0.07% of cases resulted in hospitalization; and no patient died. Although this study relies on older data, there is no reason to think that abortion has become less safe over the past 3 decades; on the contrary, as noted previously, abortion mortality data demonstrate that the safety of abortion increased over time and has been stable in recent years.

Safety of Legal Induced Abortion Compared to Other Pregnancy Outcomes

23. Legal induced abortion is substantially safer than childbirth. In 2012, a colleague and I published an analysis comparing abortion-associated mortality to mortality from childbirth in the United States over the years 1998-2005.[8] We found that in those years, the mortality rate from legal abortion was 0.63 deaths

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[7] Hakim-Elahi E, Tovell HM, Burnhill MS. Complications of first-trimester abortion: a report of 170,000 cases. Obstet Gynecol 1990;76:129-35.

[8] Raymond EG, Grimes DA. The comparative safety of legal induced abortion and childbirth in the United States. Obstet Gynecol 2012;119:215-9 (P-087).

per 100,000 abortions, whereas the pregnancy-associated death rate among women known to have delivered live neonates in the United States was 8.8 deaths per 100,000 live births. Thus, the risk of death associated with childbirth was approximately 14 times higher than the death rate from abortion.

24. In Texas, the maternal mortality ratio is very high, and it has been increasing in recent years, according to data gathered and compiled by DSHS. In contrast, the mortality ratio from abortion is comparable to the national average, according to the same data. A table comparing these two outcomes is presented below. During the entire period 2001-2012, DSHS reports that the total number of maternal deaths in Texas was 944. In comparison, the total number of abortion-related deaths was 5.

Table 2. Comparison of mortality ratios associated with live birth and abortion among Texas residents, 2001-2012, as reported by DSHS.

Year	Live births	Maternal Deaths	Maternal deaths per 100,000 live births	Abortions	Abortion Deaths	Abortion deaths per 100,000 abortions
2012	382,438	121	31.6	66,098	0	0.0
2011	377,274	116	30.7	70,003	0	0.0
2010	385,746	95	24.6	74,959	0	0.0
2009	401,599	116	28.9	74,835	0	0.0
2008	405,242	90	22.2	78,330	1	1.3
2007	407,453	75	18.4	77,811	0	0.0
2006	399,309	90	22.5	79,041	0	0.0
2005	385,537	60	15.6	74,399	1	1.3
2004	381,441	47	12.3	72,441	1	1.4
2003	377,374	60	15.9	76,019	0	0.0
2002	372,369	34	9.1	76,278	1	1.3
2001	365,092	40	11.0	74,101	1	1.3

Source: DSHS, Vital Statistics Annual Reports, 2001-2012, *available at* http://www.dshs.state.tx.us/chs/vstat/annrpts.shtm

25. The disparity between abortion and childbirth is not surprising. Pregnancies ending in abortion are substantially shorter than those ending in childbirth and thus entail less time for pregnancy-related problems to occur. Many dangerous pregnancy-related complications such as pregnancy-induced hypertension and placental abnormalities manifest themselves in late pregnancy; early abortion avoids these hazards. Moreover, in the United States in 2008, one third of births occurred by cesarean delivery, an abdominal operation with substantial morbidity.

26. Indeed, our 2012 paper may have underestimated the relative safety of having an abortion over continuing a pregnancy. Due to data limitations, our comparison was limited to live births; we omitted other pregnancy outcomes, including stillbirths and ectopic pregnancies, which are outcomes associated with higher risks of death than live birth.[9]

27. The safety of legal induced abortion relative to childbirth has increased over the past 40 years. In 1972, the abortion-related mortality rate was estimated as about one quarter the maternal death rate in women who continued their pregnancies to live birth.[10] Over the subsequent 7 years, the relative risk

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[9] Grimes DA. Estimation of pregnancy-related mortality risk by pregnancy outcome, United States, 1991 to 1999. Am J Obstet Gynecol 2006;194:92-4.

[10] LeBolt SA, Grimes DA, Cates W, Jr. Mortality from abortion and childbirth. Are the populations comparable? JAMA 1982;248:188-91.

had declined to about one seventh. As noted, in the years 1998-2005, it was about one fourteenth.

Safety of Legal Induced Abortion Compared to Other Outpatient Medical Procedures

28. Several recent studies demonstrate that legal induced abortion as currently performed is comparable in safety to, or even safer than, other procedures commonly performed in outpatient settings.

29. For example, an analysis of outcomes of outpatient plastic surgery cases (most commonly breast augmentation and related procedures, liposuction, mastopexy and reduction, facelift and related procedures, and abdominplasty) between 2001 and 2012 found 94 deaths after 5,525,225 procedures, which is a mortality rate of 1.7 deaths per 100,000 procedures.[11] Thus the death rate from these procedures is about 2.6 times the rate from abortion as currently performed (0.69 deaths/100,000). This study focused on procedures performed in ASCs accredited by the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), but these types of plastic surgery procedures are also performed in office-based settings.

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[11] Soltani AM, Keyes GR, Singer R, Reed L, Fodor PB. Outpatient surgery and sequelae: an analysis of the AAAASF Internet-based quality assurance and peer review database. Clin Plast Surg 2013;40:465-73.

30. Colonoscopy is also commonly performed in outpatient medical facilities. Across 13 studies published between 2000 and 2010 that included a combined total of more than 421,000 colonoscopies,[12]

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[12] Levin TR, Zhao W, Conell C, et al. Complications of colonoscopy in an integrated health care delivery system. Ann Intern Med 2006;145:880-6; Ko CW, Riffle S, Michaels L, et al. Serious complications within 30 days of screening and surveillance colonoscopy are uncommon. Clin Gastroenterol Hepatol 2010;8:166-73; Rabeneck L, Paszat LF, Hilsden RJ, et al. Bleeding and perforation after outpatient colonoscopy and their risk factors in usual clinical practice. Gastroenterology 2008;135:1899-906, 906 el; Imperiale TF, Wagner DR, Lin CY, Larkin GN, Rogge JD, Ransohoff DF. Risk of advanced proximal neoplasms in asymptomatic adults according to the distal colorectal findings. N Engl J Med 2000;343:169-74; Viiala CH, Zimmerman M, Cullen DJ, Hoffman NE. Complication rates of colonoscopy in an Australian teaching hospital environment. Intern Med J 2003;33:355-9; Gatto NM, Frucht H, Sundararajan V, Jacobson JS, Grann VR, Neugut AI. Risk of perforation after colonoscopy and sigmoidoscopy: a population-based study. J Natl Cancer Inst 2003;95:230-6; Korman LY, Overholt BF, Box T, Winker CK. Perforation during colonoscopy in endoscopic ambulatory surgical centers. Gastrointest Endosc 2003;58:554-7; Anderson ML, Pasha TM, Leighton JA. Endoscopic perforation of the colon: lessons from a 10-year study. Am J Gastroenterol 2000;95:3418-22; Nelson DB, McQuaid KR, Bond JH, Lieberman DA, Weiss DG, Johnston TK. Procedural success and complications of large-scale screening colonoscopy. Gastrointest Endosc 2002;55:307-14; Sieg A, Hachmoeller-Eisenbach U, Eisenbach T. Prospective evaluation of complications in outpatient GI endoscopy: a survey among German gastroenterologists. Gastrointest Endosc 2001;53:620-7; Tran DQ, Rosen L, Kim R, Riether RD, Stasik JJ, Khubchandani IT. Actual colonoscopy: what are the risks of perforation? Am Surg 2001; 67:8457; discussion 7-8; Rathgaber SW, Wick TM. Colonoscopy completion and complication rates in a community gastroenterology practice. Gastrointest Endosc 2006;64:556-62; Pickhardt

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the mortality rate related to colonoscopy was at least 5 deaths/100,000 procedures, nearly 10 times higher than the abortion-related mortality rate. A literature review conducted for the United States Preventive Services Task Force and published in 2008 found that the risk of serious morbidity from screening colonoscopy conducted in predominantly asymptomatic persons was 0.28%. The complications included bowel perforations, gastrointestinal hemorrhage, diverticulitis, cardiovascular events, severe abdominal pain, and death. These data suggest that abortion is safer than colonoscopy.

Management of Complications Arising from Abortion

31. As previously noted, the types of serious complications that may occur following a surgical abortion include hemorrhage, infection, surgical trauma such as uterine perforation, anesthesia complications, incomplete abortion, and embolism. Continuing pregnancy and ectopic pregnancy are sometimes also reported as complications, although the former is really abortion failure and the latter is clearly unrelated to the abortion procedure. Potential complications of a medical abortion are qualitatively similar except that surgical trauma and anesthetic reactions

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PJ, Choi JR, Hwang I, et al. Computed tomographic virtual colonoscopy to screen for colorectal neoplasia in asymptomatic adults. N Engl J Med 2003;349:2191-200.

are avoided if the medical abortion is successful. Medical abortifacients are not 100% effective; some patients undergoing medical abortion require repeated doses or a surgical abortion to complete the pregnancy termination.

32. Some complications of abortion may occur during or shortly after a surgical abortion procedure, or they may be recognized at a follow-up appointment at the abortion facility. These complications can almost always be managed at the abortion facility itself. As illustrated by the data presented above, complications requiring that a patient be sent from an abortion facility to a hospital are very rare.

33. Abortion complications may also present when the patient is at home. This is almost universally true of acute complications of medical abortion because the abortifacient drugs take time to exert their effects, and thus the abortion itself almost always occurs after the patient has left the abortion facility. Again, complications occurring out of the office are rarely emergencies and can almost always be managed on an outpatient basis, either at the abortion facility or at another outpatient point of care. In the very rare instances in which emergency hospitalization is required, the patient should be transported from her present location directly to a nearby hospital. She should not travel out of her way to be treated at a hospital that is within 30 miles of the facility where her abortion was performed even if the abortion provider has admitting privileges there.

The Admitting Privileges Requirement is Contrary to National Standards for Outpatient Surgery

34. To examine the standards of practice across medical fields regarding the need for physicians performing outpatient medical and surgical procedures to have admitting privileges at a nearby hospital, I have reviewed guidelines from three national organizations that accredit healthcare facilities, and four professional societies.

35. First, the Association for Ambulatory Health Care (AAAHC) currently accredits more than 5,000 organizations in a wide variety of ambulatory health care settings and is the official accrediting organization for the US Air Force and the US Coast Guard. The AAAHC "2013 Accreditation Handbook for Office-Based Surgery"[13] states the following:

> "When emergencies or unplanned outcomes occur, and hospitalization is indicated for the evaluation and stabilization of the patient, the organization shall have one [bolded in original] of the following:
>
> - A written transfer agreement for transferring patients to a nearby hospital.
> - A written policy of credentialing and privileging only physicians and dentists

[13] Accreditation Handbook For Office-Based Surgery Including Review Guidelines. Skokie, IL: Accreditation Association for Ambulatory Health Care, Inc.; 2013 (P-189).

who have admitting and similar privileges at a nearby hospital.

- A written agreement with a physician or provider group with admitting privileges at a nearby hospital.
- A detailed written procedural plan for handling medical emergencies."

The AAAHC explicitly recognizes three acceptable alternatives to a physician having admitting privileges at a local hospital.

36. Second, the AAAASF, previously mentioned, accredits more than 2000 ambulatory surgery facilities in the United States. This organization's "Regular Standards and Checklist for Accreditation of Ambulatory Surgery Facilities, Version 14",[14] published in January 2014, has two provisions that are relevant here. Standard 400.21, dealing with medical emergencies, provides that:

> "There is a written transfer agreement with a local accredited or licensed acute care hospital within 30 minutes which is approved by the facility's medical staff, or the operating surgeon has privileges to admit patients to such a hospital."

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[14] Regular Standards and Checklist for Accreditation of Ambulatory Surgery Facilities, Version 14. Gurnee, IL: American Association for Accreditation of Ambulatory Surgery Facilities 2014 (P-190).

Thus, this standard recognizes having a written transfer agreement as an acceptable alternative to a physician having admitting privileges.

In addition, Standard 800.10, concerning physician credentialing, provides that:

> Physicians, podiatrists, or oral and maxillofacial surgeons who operate in facilities accredited by AAAASF must hold or demonstrate that they have held valid, unrestricted hospital privileges in their specialty at an accredited and/or licensed hospital. Only surgical procedures included within those hospital privileges may be performed within the AAAASF-accredited facility. If the privilege-granting hospital does not possess equipment or technology to allow a physician, podiatrist, or oral and maxillofacial surgeon to be credentialed for a specific surgery, the physician, podiatrist, or oral and maxillofacial surgeon may provide alternative evidence of training and competence in that surgery. Individual consideration will be given if the physician, podiatrist, or oral and maxillofacial surgeon no longer possesses or cannot obtain such privileges, and can demonstrate that loss of or inability to obtain such privileges was not related to lack of clinical competence, ethical issues or problems other than economic competition. (800.010.020)

It further provides that:

> If the physician, podiatrist, or oral and maxillofacial surgeon does not hold admitting

> privileges at a hospital within 30 minutes of the facility, there must be a signed and dated document from a person in the same specialty who has admitting privileges in a hospital within 30 minutes of the facility that indicates their willingness to admit the patient to the hospital. (800.010.025).

The AAAASF thus recognizes that having current admitting privileges at a local hospital is not the only acceptable way to demonstrate clinical competence to perform surgical procedures. The Standards explicitly state that alternate evidence of training and competence can also be satisfactory in certain circumstances and that loss of or inability to obtain local hospital privileges may be unrelated to lack of clinical competence. The Standards provide a specific alternative to having current admitting privileges, which is to have an agreement with another physician who does have privileges.

37 Third, the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations or JCAHO) accredits and certifies more than 20,000 health care organizations and programs in the United States. This organization's "2014 Comprehensive Accreditation Manual for Office-Based Surgery"[15] includes no requirement that clinicians performing office-based surgery have hospital

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[15] 2014 Comprehensive Accreditation Manual for Office-Based Surgery. Oakbrook Terrace, IL: Joint Commission; 2014 (P-191).

privileges. Rather, it specifies that a facility must have a process for external transfers and for shifting responsibility for the patient's care to another provider in emergency and non-emergency situations, and that this process must ensure coordination with other health care providers based on the patient's needs.

38. Fourth, ACOG's "Guidelines for Women's Health Care" (3d edition),[16] published in 2007, provide (page 433) that: "Clinicians who perform abortions in their offices, clinics, or freestanding ambulatory care facilities should have a plan to provide prompt emergency services if a complication occurs and should establish a mechanism for transferring patients who require emergency treatment." The Guidelines do not require physicians who perform abortion procedures in outpatient settings to have admitting privileges.

39. Fifth, in 2003, the American College of Surgeons issued a set of 10 core principles regarding office-based surgical procedures. These principles, titled "Patient Safety Principles for Office-Based Surgery Utilizing Moderate Sedation/Analgesia, Deep Sedation/Analgesia, or General Anesthesia," (http://www.facs.org/patientsafety/patientsafety.html, accessed 12 June 2014) represent a consensus by a majority of the surgical community in the United States. Like the

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[16] American College of Obstetricians and Gynecologists. Guidelines for Women's Health Care: A Resource Manual. 3rd ed. Washington, DC: American College of Obstetricians and Gynecologists; 2007 (P-192).

guidelines from the accreditation bodies, these principles make clear that hospital admitting privileges are not required for the safe performance of outpatient surgery if certain other criteria are met. In particular, Core Principle No. 4 provides that: "Physicians performing office-based surgery must have admitting privileges at a nearby hospital, or a transfer agreement with another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital."

40. Sixth, the American Society of Anesthesiologists reaffirmed its "Guidelines for Ambulatory Anesthesia and Surgery"[17] in 2013 and its "Guidelines for Office-Based Anesthesia" in 2009[18] (https://www.asahq.org/For-Members/Standards-Guidelines-and-Statements.aspx, accessed 12 June 2014). These documents state that physicians operating in ambulatory settings should be licensed and that the facility should have a written protocol in place for the safe and timely transfer of patients to a prespecified alternate care facility when extended or emergency services are needed to protect the health or well-being of the patient. The guidelines do not include any requirement that any personnel at the facility have hospital admitting privileges.

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[17] American Society of Anesthesiologists. Guidelines for Office-Based Anesthesia. 2009 (P-193).

[18] American Society of Anesthesiologists. Guidelines for Ambulatory Anesthesia and Surgery. 2013 (P-194).

41. Seventh, the 2014 Clinical Policy Guidelines of the National Abortion Federation (NAF),[19] require that protocols for the management of emergencies must be in place, and encourage member clinics to "consider developing a transfer agreement with a hospital outlining the means of communication and transport and the protocol for emergent transfer of care." The NAF guidelines are thus entirely consistent with those of the six other organizations.

42. The standards and guidelines of these seven organizations explicitly confirm that, while medical facilities are expected to have mechanisms in place to ensure that physicians are qualified to perform the procedures that they provide and that patients experiencing medical emergencies will be swiftly and safely transported to a hospital, admitting privileges at a local hospital are not part of accepted medical practice and are not needed to ensure safety of medical and surgical procedures in outpatient settings. Other mechanisms, such as the creation of a detailed policy for managing medical emergencies or the maintenance of a backup agreement with a physician who has admitting privileges, are acceptable to ensure appropriate patient transfer in emergency situations.

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[19] National Abortion Federation. Clinical Policy Guidelines. 2014 (P-195).

There is No Medical Basis for the ASC Requirement

43. No evidence exists to suggest that abortion is safer when performed in ASCs than when performed in other outpatient settings.

44. As explained above, abortion is safer than other surgical procedures that are performed in office-based settings, including plastic surgeries and colonoscopies.

45. ACOG's "Guidelines for Women's Health Care" (3d edition)[20] recognize that abortion procedures may appropriately be performed in doctor's offices and clinics. Indeed the Guidelines (page 432) specifically denounce the imposition of "obstacles [to abortion access] such as facility regulations that are more stringent than for other surgical procedures of similar risk"

46. Patients undergoing procedures like surgical and medical abortion, which are not performed in an aseptic surgical field, derive no medical benefit from the type of precautions that are taken to maintain a sterile environment during procedures that are performed in an aseptic surgical field.

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[20] American College of Obstetricians and Gynecologists. Guidelines for Women's Health Care: A Resource Manual. 3rd ed. Washington, DC: American College of Obstetricians and Gynecologists; 2007 (P-192).

47. In considering the ASC requirement of HB2, I examined guidelines produced by the Facility Guidelines Institute (FGI), an organization that exists for the purpose of developing research-based guidelines for medical facilities aimed at advancing quality healthcare. FGI's guidelines represent a consensus by leading architects, engineers, clinicians, and regulators concerning appropriate standards for the design and construction of different types of health care facilities. FGI's 2014 Guidelines for Design and Construction of Hospitals and Outpatient Facilities[21] distinguish between invasive procedures and non-invasive procedures. The FGI Guidelines define "invasive procedure" as follows:

"A procedure that:

- Penetrates the protective surfaces of a patient's body (e.g., skin, mucous membranes, cornea).
- Is performed in an aseptic surgical field (i.e., a procedure site).
- Generally requires entry into a body cavity.
- May involve insertion of an indwelling foreign body.

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[21] Facilities Guidelines Institute. 2014 Guidelines for Design and Construction of Hospitals and Outpatient Facilities. Chicago, IL: Facilities Guidelines Institute; 2014 (P-196).

> Note. . For the purposes of this document, the term is limited to the above description. The intent is to differentiate those procedures that carry a high risk of infection, either by exposure of a usually sterile body cavity to the external environment or by implantation of a foreign object(s) into a normally sterile site. Procedures performed through orifices normally colonized with bacteria and percutaneous procedures that do not involve an incision deeper than skin would not be included in this definition." (xxxiv-xxxv)

48. Surgical abortion does not satisfy FGI's definition of "invasive procedure" because it is performed through the vagina, an orifice that is normally colonized with bacteria. And of course, medical abortion does not satisfy the definition either.

49. Compared to facilities where non-invasive procedures are performed, the FGI Guidelines recommend that facilities where invasive procedures are performed comply with more rigorous construction standards aimed at maintaining a sterile operating environment. For example, invasive procedures must be performed in an "operating room" that is at least 250 square feet in area, while non-invasive procedures may be performed in a much smaller "procedure room." The Guidelines provide that "[t]he minimum square footage for an operating room was determined by combining [among other things] a space of approximately 4 feet (1.22 meters) for a

minimum safe traffic pathway on all four sides of the sterile field." (page 311, app. A3.7-3.3.1.1)

50. Thus, the FGI Guidelines demonstrate that to require abortion facilities to meet the same construction standards as facilities where procedures that entail an aseptic operating field are performed is a departure from accepted standards in the healthcare field.

Diminished Access to Legal Abortion Threatens Public Health

51. As summarized above, substantial data demonstrate manifestly that abortion as currently practiced is very safe. The proposition that restrictions such as those in HB2 will enhance abortion safety further is entirely unsupported by evidence.

52. On the contrary, I am concerned that these requirements are detrimental to the health of women.

53. I understand that they are expected to substantially reduce the number and geographic distribution of abortion providers in Texas. As a result, the distance that women will need to travel on average to obtain abortion services will increase, as will the cost of obtaining these services.

54. Several studies have shown that travel and procedure costs are a common reason for delaying

abortion.[22] As these difficulties worsen for women in Texas, I expect that the proportion of women who delay their abortions will increase.

55. And delay, in turn, increases the risk of the abortion procedure. As previously noted, although abortion is overall very safe throughout pregnancy, the risks of both morbidity and mortality from abortion increase with gestational age. *See* Fn. 1

56. Moreover, if the difficulty and cost of obtaining abortion is severe, some women may delay to the point that they cannot obtain abortion at all. A study of the impact of a Texas law that resulted in a reduction of the number of providers in the state who performed abortions at 16 weeks gestation or later found evidence of such an effect.[23] Similarly, a recent survey included 231 women who were delayed in obtaining abortion services until they had reached such an advanced gestational age that they were unable to find a provider within 150 miles who could perform the abortion. *See* Fn. 22 The gestational limits of the providers in the survey ranged from 10

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[22] Finer LB, Frohwirth LF, Dauphine LA, Singh S, Moore AM. Timing of steps and reasons for delays in obtaining abortions in the United States. Contraception 2006;74:334-44; Upadhyay UD, Weitz TA, Jones RK, Barar RE, Foster DG. Denial of Abortion Because of Provider Gestational Age Limits in the United States. Am J Public Health 2013.

[23] Colman S, Joyce T. Regulating Abortion: Impact on Patients and Providers in Texas. Journal of Policy Analysis and Management 2011;30:775-97 (P-152).

to 26 weeks. In most of these cases, the delays were due in part to difficulties negotiating the cost of the procedure and the distance to the nearest abortion provider. Most of these women continued their pregnancies to delivery, which, as I noted above, is much more detrimental to the health and wellbeing of a woman with an unwanted pregnancy than abortion. Fewer than a third made the journey of over 150 miles to obtain an abortion.

57 Additionally, some women who cannot readily obtain legal abortion services may instead opt for illegal abortion or attempt self-induction of abortion. One recent study of women in 4 states (including Texas) found that at least one third of women who attempted self-induction of abortion cited cost or distance as reasons for their decisions to self-induce.[24] Both illegal abortion and self-induction are substantially less safe than legal induced abortion.[25] The World Health Organization (WHO) has estimated that "Even in developed countries, the case—fatality rate for unsafe abortion is 40 times higher than that for legal induced abortion."[26]

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[24] Grossman D, Holt K, Pena M, et al. Self-induction of abortion among women in the United States. Reprod Health Matters 2010;18:136-46 (P-160).

[25] Grimes DA, Benson J, Singh S, et al. Unsafe abortion: the preventable pandemic. Lancet 2006;368:1908-19.

[26] World Health Organization. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and

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58. A review published this month by researchers from Harvard School of Public Health, WHO, and the United Nations Population Fund found that, across the world, legal restrictions on access to abortion are associated with higher rates of unsafe abortion and higher maternal mortality due to unsafe abortion. This review also concluded that "Methods of induced abortion, including medical abortion and surgical methods such as manual vacuum aspiration, as recommended by WHO, are . among the safest clinical interventions available in health care today."[27]

Summary

59. Legal induced abortion as currently practiced in the United States is a very safe procedure. The abortion-associated mortality rate is extremely low and has been stable for more than 3 decades.

60. Abortion is safer than childbirth and as safe or safer than many other surgical procedures commonly performed in outpatient settings.

61. Requirements that abortion providers must have admitting privileges at local hospitals and that abortion must be provided in ASCs are unnecessary to improve the safety of abortion and depart from

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associated mortality in 2008, 6th ed. Geneva: World Health Organization; 2008.

[27] Shah IH, Ahman E, Ortayli N. Access to safe abortion: progress and challenges since the 1994 International Conference on Population and Development (ICPD). Contraception 2014.

accepted medical practice. Existing data clearly show that abortion complications can be safely managed without these requirements.

62. In fact, by reducing the number and distribution of legal abortion providers, I expect that such requirements will be detrimental to women's health because they will cause women to delay their abortions or to forgo the procedure altogether, and they may prompt some women to seek illegal abortion or self-induction. These effects would increase women's health risk.

Dated: August 3, 2014
Austin, Texas

By: /s/ Elizabeth Raymond
Elizabeth Gray Raymond,
M.D., M.P.H.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH; *et al.*,	)	
Plaintiffs,	)	CIVIL ACTION
v.	)	CASE NO. 14-CV-284-LY
DAVID LAKEY, M.D.; *et al.*,	)	
Defendants.	)	

DIRECT TESTIMONY OF
GEORGE W. JOHANNES, AIA

(Filed Aug. 4, 2014)

GEORGE W. JOHANNES, AIA, under penalty of perjury, testifies as follows:

1. I am an architect licensed in the State of Missouri and a member of the American Institute of Architects, St. Louis Chapter. I have been practicing architecture for more than 40 years. I hold a Bachelor of Arts in architecture and a Master of Architecture from Washington University in St. Louis. Since 2006, I have been the owner and principle of my own firm, George W. Johannes, AIA Architect; between 1980 and 2006, I was the managing partner, president, or principle of several other architecture firms. I am also a Senior Lecturer in the Sam Fox School of Design & Visual Arts at Washington University in St. Louis, where I have taught for twenty years. I have designed over $300,000,000 in industrial, commercial,

residential, and infrastructure projects that have been built throughout North America A full listing of my professional activities is included in my professional biography, annexed as P-004.

2. Since the 1990s, I have worked on approximately twenty abortion facility projects, including designing a new abortion clinic that met state requirements for licensure as an ambulatory surgical center ("ASC") in Illinois. I have also worked on several projects for health care facilities other than abortion clinics, including hospitals, surgical facilities, and doctors' offices.

3. As part of my work, I regularly consult with contractors and construction managers to price the costs of my clients' projects. Typically, multiple cost estimates are developed and provided, each one more comprehensive than the last, as a project moves from the initial conceptual design through to producing technical drawings and then into actual construction. I also teach cost estimating as a unit in my class at Washington University; the project I use as a real-world example for my students is an ASC that was built about four years ago in Illinois.

4. I am testifying as an expert in the design and construction of health care facilities. My opinions are based on my education, teaching and years of professional experience as a practicing architect; my knowledge of the relevant literature; my consultation with contractors who have recent experience building ASC facilities throughout the country; and surveys

that I personally undertook of each of the Plaintiffs' clinics.

5. I am familiar with the requirements of Texas House Bill No. 2 ("H.B. 2"), including the "ASC requirement," which mandates that "the minimum standards for an abortion facility must be equivalent to the minimum standards for ambulatory surgical centers" contained in Chapter 135 of Title 25 of the Texas Administrative Code.

6. The ASC requirement is inconsistent with prevailing standards for the design and construction of healthcare facilities in at least three respects: (1) it does not permit existing abortion facilities to continue to operate under existing standards, a practice commonly known as "grandfathering," and it does not permit abortion facilities to obtain waivers from specified standards when patient health and safety would not be compromised; (2) it subjects abortion facilities, which perform procedures that do not entail an aseptic surgical field, to standards intended for facilities performing procedures that do entail an aseptic surgical field; and (3) it fails to distinguish between facilities in which four or more patients are simultaneously incapable of taking action for self-preservation under emergency conditions without the assistance of others due to the nature of their illness, injury, treatment, or level of anesthesia, and facilities at which that is not the case.

7. None of the seven licensed abortion facilities that were operated by Plaintiffs prior to the enactment of H.B.2 currently meets the minimum standards for ambulatory surgical centers under Texas law. Additionally, it would not be possible for any of the clinics to undertake renovations within their existing footprints to come into compliance with those standards because each existing footprint is too small. Finally, of the seven clinics, only three have the necessary lot size to permit the expansion that would be necessary to meet the minimum ASC standards. I estimate the respective costs of expanding each of these clinics at $2.6 million, $2.4 million, and $1.7 million. I understand, however, that two of the three clinics operate in facilities that they lease rather than own, and the terms of their leases would not permit them to undertake a major expansion. Building an entirely new ASC would cost even more than expanding an existing facility: approximately $3.4 million for an ASC with two operating rooms (not including the cost of land).

ASC Requirement

8. The ASC requirement provides that abortion clinics must comply with the standards for new construction set forth in Texas Administrative Code, Title 25, Chapter 135, which establish numerous detailed requirements for the construction of ambulatory surgical centers. In addition, the regulations incorporate the requirements of the 2003 edition of the National Fire Protection Association 101: Life

Safety Code ("NFPA 101"), Chapters 1 thru 10 & 20, and portions of several other referenced NFPA publications, including those for electrical systems; heating, ventilation, and air conditioning ("HVAC"); and plumbing installations.

9. Neither grandfathering of existing facilities nor the granting of waivers from specific requirements is permitted.

Prevailing Standards for the Design and Construction of Healthcare Facilities

10. Prevailing standards for the design and construction of various types of buildings, including healthcare facilities, are set forth in model building codes such as the International Building Code ("IBC"), the NFPA 101, and the Facilities Guidelines Institute's Guidelines for Design and Construction of Hospitals and Outpatient Facilities ("FGI Guidelines"). These codes are generated by councils composed of individuals with diverse expertise, including fire marshals, code enforcers, engineers, architects, business owners, healthcare professional, developers and other interested and knowledgeable experts.

11. Model building codes are evidence-based; that is, they are based on a continuous and exhaustive process of research that entails gathering data from throughout the nation and around the world. This research is reflected in the publication of revised versions of these codes, typically every three years. Based on evidence concerning a given edition's

performance, subsequent editions may make some code provisions stricter, while relaxing or eliminating others that created unnecessary expense while providing no safety benefit.

12. As set forth below, the ASC requirement is inconsistent with prevailing standards set forth in model building codes in several respects.

Grandfathering and Waivers

13. First, model building codes embody the principle that regulations must balance the protection of life safety with the realities of cost and disruption to services and businesses. Accordingly, as new code editions are published or adopted, it is virtually unheard of for new regulations to be retroactively required of existing businesses or real estate. If additions are sought to facilities, the addition typically must meet current codes, but the original building need not. Recent IBC development has established a gradient of code application to existing buildings based upon the amount of modification that is sought.

14. To require continual upgrading of buildings as the new code editions are issued rather than "grandfathering" existing construction would be economically disastrous and chaotic. Most buildings would be under virtually constant renovation to keep up with code refinements, and there would be little hope of predictability when making decisions about starting an enterprise or building a facility. This is as true for health care occupancies as for all other

occupancies. Thus, only in extreme circumstances in which a building presents a clear, documented (not hypothetical) hazard to its occupants, would a building code typically not allow that building to be grandfathered.

15. Similarly, prevailing standards recognize that waivers from specific code requirements should be granted when an alternative would not pose a threat to public health or safety.

16. I understand that, although Texas law generally permits grandfathering under the ASC standards, it does not permit abortion facilities to be grandfathered. Likewise, I understand that, while Texas law generally permits the granting of waivers from ASC standards when patient health and safety would not be compromised, it does not permit the granting of waivers to abortion facilities under any circumstances.

17. This is a radical departure from prevailing standards for building regulation in general, and from the standards governing design and construction of healthcare facilities in particular. In my experience, it is common practice to permit grandfathering of existing healthcare facilities and to permit the granting of waivers to such facilities when patient health or safety would not be compromised.

18. For example, I recently consulted with a group of abortion providers in Michigan for the purpose of helping them to become licensed under a 2012 law requiring abortion facilities to meet the

standards for "Freestanding Surgical Outpatient Facilities." Unlike in Texas, the Michigan law permitted abortion facilities to obtain waivers from the applicable standards when patient health and safety would not be compromised. At least three of the abortion facilities with which I worked became licensed after receiving waivers from the following requirements:

- A requirement that each of the facility's procedure rooms provides a minimum of 120 square feet of usable floor space;
- A requirement that the facility have a soiled utility room that is separate from its sterilization room; and
- Requirements concerning the size and layout of the patient recovery area.

19. The FGI Guidelines confirm that allowance of grandfathering and waivers is the prevailing standard for regulation of healthcare facilities. First, they are intended to apply only to new construction and major renovations, not existing facilities (1.1-1.2.1).[1] Further, they expressly call on regulators to permit waivers in appropriate cases. For example, the preface to the Guidelines states: "It is intended that when used as regulation, some latitude be granted in complying with the Guidelines requirements as long as the health and safety of the facility's occupants are

[1] All references to the FGI Guidelines are to the 2014 edition.

not compromised" (xxiv). Sections on Exceptions (1.1-3.1.2) and Equivalency Concepts (1.1-6) reinforce this position.

Aseptic Surgical Field

20. Second, prevailing standards for healthcare facility construction distinguish between procedures that are performed in an aseptic surgical field and those that are not. Facilities in which the former types of procedures are performed are subject to more rigorous standards because, as I understand it, patients undergoing such procedures are at much greater risk of infection.

21. For example, the FGI Guidelines distinguish between "invasive procedures" and "non-invasive procedures." An invasive procedure is defined as:

"A procedure that:

- Penetrates the protective surfaces of a patient's body (e.g., skin, mucous membranes, cornea).
- Is performed in an aseptic surgical field (i.e., a procedure site).
- Generally requires entry into a body cavity.
- May involve insertion of an indwelling foreign body.

Note:. For the purposes of this document, the term is limited to the above description.

> The intent is to differentiate those procedures that carry a high risk of infection, either by exposure of a usually sterile body cavity to the external environment or by implantation of a foreign object(s) into a normally sterile site. Procedures performed through orifices normally colonized with bacteria and percutaneous procedures that do not involve an incision deeper than skin would not be included in this definition" (xxxiv-xxxv).

22. I understand that surgical abortion does not satisfy FGI's definition of "invasive procedure" because it is not performed in an aseptic surgical field but, rather, is performed through the vagina, an orifice that is normally colonized with bacteria.

23. Under the FGI Guidelines, compared to facilities where non-invasive procedures are performed, facilities where invasive procedures are performed are subject to more rigorous construction standards that are aimed at maintaining a sterile operating environment during surgery.

24. For example, invasive outpatient procedures must be performed in an "operating room" (3.7-3.3) that is at least 250 square feet in area, while non-invasive outpatient procedures may be performed in a much smaller "procedure room" (3.8-3.1). The FGI Guidelines explain that "[alit office procedure room is a space(s) for the performance of procedures that do not require a restricted environment but may require the use of sterile instruments or supplies" (A3.8-3.1).

25. Similarly, operating rooms where invasive outpatient procedures are performed must have adjacent "hand scrub facilities" (3.1-3.3), while procedure rooms where non-invasive outpatient procedures are performed need only have a "hand washing station" (3.1-3.6.5).

26. Many of the minimum standards for ASCs under Texas law are aimed at preserving a sterile operating environment during surgery. These include standards concerning the square footage of operating rooms; scrub facilities; maintenance of a one-way traffic pattern through the facility; ceiling, wall, and floor finishes; separation of soiled utility and sterilization rooms; air pressure and filtration; and humidity control. Application of such standards to facilities that do not perform surgeries entailing an aseptic surgical field is a departure from prevailing standards.

Patients Incapable of Self-Preservation

27. Third, the ASC requirement also departs from prevailing standards for the design and construction of healthcare facilities by subjecting abortion facilities to the requirements of chapter 20 of the NFPA 101 without regard to the number of patients at the facility at any given time who would be incapable of taking action for self-preservation under emergency conditions without the assistance of others.

28. The NFPA 101 is a model code concerning fire safety requirements that has been widely adopted throughout jurisdictions in the United States. Under NFPA 101, an outpatient healthcare facility may be treated either as a business occupancy, subject to the requirements of chapter 38 (new business occupancies) or chapter 39 (existing business occupancies), or as an ambulatory health care occupancy, subject to the far more stringent requirements of chapter 20 (new ambulatory health care occupancies) or chapter 21 (existing ambulatory health care occupancies). How a facility is classified depends on the number of patients that may be present in the facility at any given time who would be incapable of taking action for self-preservation under emergency conditions without the assistance of others. If four or more such patients may be present in the facility at one time, then the facility is classified as an ambulatory health care occupancy. If three or fewer such patients may be present in the facility at one time, then the facility is classified as a business occupancy.

29. Pursuant to the ASC requirement, abortion facilities are automatically subject to the requirements for new ambulatory health care occupancies regardless of the number of patients who would be incapable of self-preservation in an emergency. But based on the work I have done with abortion facilities around the country, I know that abortion facilities that do not utilize general anesthesia or deep sedation typically do not have patients who would be incapable of self-preservation in an emergency.

Accordingly, the ASC requirement subjects most abortion providers to far more stringent fire safety standards than the NFPA 101 would on its face. That is a clear departure from prevailing standards.

Ability of Plaintiffs' Clinics to Meet Minimum ASC Standards

Current Failure to Meet Minimum ASC Standards

30. I recently surveyed each of the following clinics operated by Plaintiffs as licensed abortion facilities prior to H.B. 2 to determine if they were in compliance with the minimum standards for ASCs under Texas law: the Whole Woman's Health clinic in Ft. Worth ("WWH—Ft. Worth"); the Whole Woman's Health clinic in Austin ("WWH—Austin"); the Whole Woman's Health clinic in San Antonio ("WWH—San Antonio"); the Whole Woman's Health clinic in McAllen ("WWH—McAllen"); Austin Women's Health Center; Killeen Women's Health Center; and Reproductive Services of El Paso. Before visiting each facility, I prepared a list of architectural elements that each clinic would have to meet to satisfy the minimum standards for ASCs under Texas law. At each facility, I conducted a visual inspection, took photographs, made measurements both inside and outside of the building, spoke with staff, and obtained plans. I spent an average of half a day at each facility. My conclusions regarding each facility's compliance with the ASC requirement are based on comparing the information I obtained during my surveys to the list of requirements I had prepared earlier.

31. I conclude that, currently, none of these clinics meets all of the minimum standards for ASCs under Texas law. For example, none has a surgical suite containing 240 square-foot operating rooms and eight-foot wide corridors. Meeting this requirement, in particular, would require significant expansion of each one of the clinics. Likewise, none of Plaintiffs' seven clinics has an HVAC ventilation and filtering system that meets the NFPA 101 standards incorporated by reference within the ASC requirement. Installing such a system in an existing facility would require significant modifications to the building. Additionally, the clinics fail to meet certain of the other minimum ASC standards, including requirements concerning scrub sinks, soiled utility areas, and storage spaces. For each facility, I have prepared a detailed site report that identifies which of the minimum ASC standards are met and which are not. These site reports are offered collectively as a trial exhibit.

Impossibility of Renovation within Existing Building Footprint

32. The minimum amount of space that an abortion clinic would need to meet the minimum standards for construction of a new ASC facility with two operating rooms is approximately 7,000 square feet. In my experience, ASCs are most often constructed to have at least two operating rooms, because this allows the medical team to treat patients in one while the other is being cleaned and prepared

for the next patient. Having two operating rooms would be especially important to ensure an efficient patient flow through an ASC that performs abortions prior to 16 weeks of pregnancy because the procedure itself is so short in duration that preparing the room would take at least as long, if not longer, than the procedure itself.[3] None of the surveyed clinics are large enough even to construct a one-operating room ASC—most are about half that size, or less. Thus, none of the clinics would be able to meet all of the ASC standards, which include the creation of a large, sterile surgical suite, by renovating within the existing building footprint.

Costs of Expansion

33. Given the impossibility of renovation within the existing building footprint, the only option remaining for conversion of existing clinics to ASCs is expansion. Each clinic would have to build an

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[3] An ASC with only a single operating room would require approximately 6,650 square feet to meet the minimum standards under Texas law. A one-operating-room ASC would be nearly as large as a two-operating-room ASC because, in either case, much of the facility's footprint would be taken up by the spaces necessary to maintain the one-way traffic pattern and separation of soiled and sterile areas, and by the eight-foot-wide corridors, both of which are needed regardless of the number of operating rooms. As mentioned in ¶ 31, above, the required size of the operating room itself is two-hundred-forty square feet, so removing one operating room would do relatively little to alter the overall size of an ASC.

addition to gain the required square footage and remodel the existing space to develop a unified floor plan that satisfies the minimum ASC standards.

34. Four of the existing clinics, Austin Women's Health Center, Killeen Women's Health Center; WWH—San Antonio; and WWH—McAllen, are not located on lots that are large enough to house 7,000 square foot facility. Further, Killeen Women's Health Center and Whole Woman's Health—San Antonio are located in multi-tenant buildings that could not accommodate expansion in any event.

35. Of the seven surveyed clinics, therefore, the only ones housed on lots that could accommodate the required expansion are WWH—Ft. Worth; WWH—Austin; and Reproductive Services of El Paso. In Table 2, below, I detail the approximate cost of these expansions. I estimate that the per-square-foot cost of the new construction would be approximately $365, which includes preparation of the site, such as leveling and clearing the land (Table 2, row F); construction of the structural portion of the addition, which includes the foundation, roof, and exterior walls (Table 2, row A); and build-out of the interior of the addition with items such as floors, interior walls, and fixed equipment (Table 2, row B). I estimate the per-square-foot cost of renovation the interior of the existing space (including any necessary demolition) would be approximately $100 (Table 2, rows D and

E).[3] In addition, the expansion and renovation of each clinic would require expenditure on non-construction costs such as interior design, furnishings, and some new medical equipment, although much of the latter could be re-used (bottom portion of Table 2, rows 1-10). I base these estimates on my years of experience as an architect as well as on consultations with contractors who have recently built ASCs, including one whose company maintains an extensive database of the cost of projects actually built, including many in Texas, and another who recently built the ASC that is used in my class as a teaching tool for cost estimating, which I mentioned in ¶3, above.

36. Expanding WWH-Ft. Worth to meet minimum ASCs standards would require the addition of 4,050 square feet of new space at a cost of $1.478 million; the renovation of 2,950 square feet of existing space at a cost of $295,000; and non-construction costs of about $828,000. Thus, the total cost of the project would be approximately $2.601 million.

37. Expanding WWH-Austin to meet minimum ASCs standards would require the addition of 3,600 square feet of new space at a cost of $1.314 million; the renovation of 3,400 square feet of existing space at a cost of $340,000; and non-construction costs of

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[3] I assume that the new construction would house the high-cost medical elements of the ASC and the existing space would house the lower-cost elements such as offices, reception, waiting rooms, and changing areas. In my professional judgment, that would be the most cost-effective way to design the facility.

about $788,000. Thus, the total cost of the project would be approximately $2.442 million.

38. Expanding Reproductive Services in El Paso to meet minimum ASCs standards would require the addition of 1,400 square feet of new space at a cost of $511,000; the renovation of 5,600 square feet of existing space at a cost of $560,000; and non-construction costs of about $593,000. Thus, the total cost of the project would be approximately $1.664 million.

39. For WWH-Austin and Reproductive Services, however, these estimates are merely a thought exercise. I understand that those clinics operate in facilities that they lease rather than own, and that the terms of their leases would not permit them to undertake a major expansion of the type described above.

Cost of New Construction

40. The cost of constructing an entirely new ASC facility is, not surprisingly, even greater than the cost of expanding and remodeling an existing facility to meet minimum ASC standards. To build a brand-new, 7,000 square-foot ASC would cost approximately $3.365 million, including non-construction costs. A detailed breakdown of the costs of building a new clinic is given in Table 1 below.[4] Additionally, a

[4] I also present in Table 1, for purposes of comparison, cost estimates for three hypothetical projects: expanding an existing 4,000 square-foot abortion clinic to turn it into 7,000 square-foot

(Continued on following page)

design for such a facility is provided in Figure 1, which is the plan for the ASC recently built in Illinois that I use as a teaching tool in the class I referred to earlier. This ASC satisfies all of the requirements for new construction set forth in Texas Administrative Code, Title 25, Chapter 135, including eight-foot corridors, one-way flow, and large surgical suites. It contains two operating rooms and measures 6,900 square feet in size. However, because this ASC is a general surgery facility, not an abortion clinic, it lacks the space for counseling patients I would expect to find in an ASC that primarily provides abortions.

41. Note that new construction would also require suitable land available for purchase or lease (my estimate does not include the price of the land) and obtaining the necessary permits and zoning variances (if any are needed) from local authorities.

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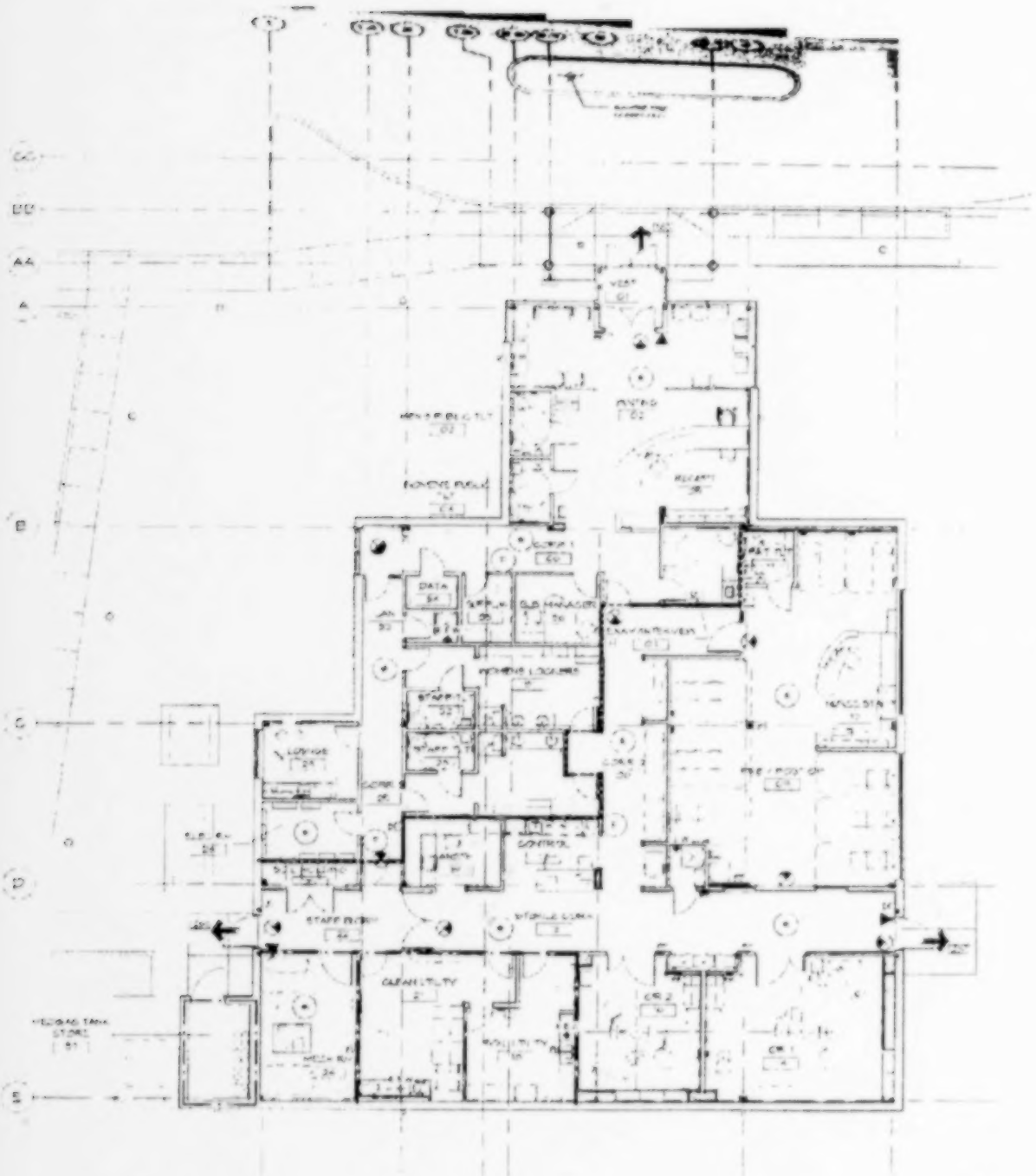
a facility that complies with the ASC requirement (this hypothetical project is most similar to those described in ¶¶ 37-39, above, and Table 2, below); building a 7,000 square-foot facility that complies with the ASC requirement within a completely empty "shell" space, such as a building already constructed but never previously occupied; and renovating an existing 7,000 square-foot abortion facility to bring it into compliance with the ASC requirement.



1 MAIN LEVEL LIFE SAFETY PLAN

Table 1
Clinic Space to ASC Conversion
Order of Magnitude Statement of Probable Cost

PROJECT COST SUMMARY

Element	Option 1—New Greenfield ASC Space			Option 2—Building Addition plus Renovation of Exist. Space			Option 3—Build-out of Existing Shell Space in an Exist. Bldg.			Option 4—Renovate Existing Space in Exist. Building		
	Area	Cost/SF	Total	Area	Cost/SF	Total	Area	Cost/SF	Total	Area	Cost/SF	Total
A New Building Shell & Core	7,000	$90.00	**$630,000**	3,000	$105.00	**$315,000**						
B Interior Tenant Improvement												
C Interior Renovation (gut & re-build)	7,000	$185.00	**$1,295,000**	3,000	$210.00	**$630,000**	7,000	$120.00	**$1,400,000**			
D Interior Renovation (Medium/Light, use existing)										4,000	$210.00	**$840,000**
E Interior Demolition (excludes Haxmat)				4,000	$95.00	**$380,000**				3,000	$95.00	**$285,000**
F Sitework				4,000	$5.00	**$20,000**				7,000	$5.00	**$35,000**
	7,000	$60.00	**$420,000**	3,000	$50.00	**$150,000**						
SUBTOTAL CONSTRUCTION COST	7,000	$335.00	**$2,345,000**	7,000	$213.57	**$1,495,000**	7,000	$200.00	**$1,400,000**	7,000	$165.71	**$1,160,000**

SOFT COSTS				
1 **Medical Equipment (allowance for new space, re-use all existing)**	**$150,000**	**$150,000**	**$150,000**	**$150,000**
2 **Furnishings (allow 2%, re-use all existing)**	**$45,900**	**$29,900**	**$28,000**	**$23,200**
3 **Telecom, MIS, TV, Cabling (allow $12/SF to new space, reuse exist.)**	**$84,000**	**$36,000**	**$64,000**	**$48,000**
4 **Signage (allow 0.6%)**	**$11,725**	**$7,475**	**$7,000**	**$5,800**
5 **Arts & plants (allow 0.6%)**	**$11,725**	**$7,475**	**$7,000**	**$5,800**
6 **A/E, Interiors & Other Consulting Fees (allow 15%)**	**$351,750**	**$224,250**	**$210,000**	**$174,000**
7 **Permits, Inspections & Testing (allow 3%)**	**$70,350**	**$44,850**	**$42,000**	**$34,600**
8 **Move/ Relocation Costs (allow 1%)**	**$23,450**	**$149,500**	**$14,000**	**$11,600**

9 Project Management Fees (allow 3.0%)	$35,175	$22,425	$21,000	$17,400
10 Owners (Construction) Contingency (allow 10%)	$234,500	$149,500	$140,000	$116,000
11 Financing & Carry Costs (by others)	*NIC*	*NIC*	*NIC*	*NIC*
12 Land acquisition (by others)	*NIC*	*NIC*	*NIC*	*NIC*
SUBTOTAL SOFT COSTS	$1,019,575	$686,825	$703,000	$585,600
TOTAL PROJECT COST	$3,364,575	$2,181,825	$2,103,000	$1,745,600

Table 2
Clinic Space to ASC Conversion
Order of Magnitude Statement of Probable Cost

PROJECT COST SUMMARY

Element	WWH—Austin			WWH—Ft. Worth			Reproductive Services—El Paso		
	Area	Cost/SF	Total	Area	Cost/SF	Total	Area	Cost/SF	Total
A New Building Shell & Core	3,600	$105.00	**$378,000**	4,050	$105.00	**$425,250**	1,400	$105.00	**$147,000**
B Interior Build-out of Shell Space	3,600	$210.00	**$756,000**	4,050	$210.00	**$850,500**	1,400	$210.00	**$294,000**
C Interior Renovation (gut & re-build)									
D Interior Renovation (Medium/Light, use existing)	3,400	$95.00	**$323,000**	2,950	$95.00	**$280,250**	5,600	$95.00	**$532,000**
E Interior Demolition (excludes Haxmat)	3,400	$5.00	**$17,000**	2,950	$5.00	**$14,750**	5,600	$5.00	**$28,000**
F Sitework	3,600	$50.00	**$180,000**	4,050	$50.00	**$202,500**	1,400	$50.00	**$70,000**
SUBTOTAL CONSTRUCTION COST	7,000	$236.29	**$1,654,000**	7,000	$259.32	**$1,773,250**	7,000	$153.00	**$1,071,000**
SOFT COSTS									
1 Medical Equipment (allowance for new space, re-use all existing)			**$150,000**			**$150,000**			**$150,000**
2 Furnishings (allow 2%, re-use all existing)			**$33,080**			**$35,465**			**$21,420**
3 Telecom, MIS, TV, Cabling (allow $12/SF to new space, reuse exist.)			**$84,000**			**$84,000**			**$84,000**
4 Signage (allow 0.6%)			**$8,270**			**$8,866**			**$5,355**
5 Arts & plants (allow 0.6%)			**$8,270**			**$8,866**			**$5,355**
6 A/E, Interiors & Other Consulting Fees (allow 15%)			**$248,100**			**$265,988**			**$160,650**

7	**Permits, Inspections & Testing (allow 3%)**	**$49,620**	**$53,198**	**$32,130**
8	**Move/Relocation Costs (allow 1%)**	**$16,540**	**$17,733**	**$10,710**
9	**Project Management Fees (allow 3.0%)**	**$24,810**	**$26,599**	**$16,065**
10	**Owners (Construction) Contingency (allow 10%)**	**$165,400**	**$177,325**	**$107,100**
11	**Financing & Carry Costs (by others)**	***NIC***	***NIC***	***NIC***
12	**Land acquisition (by others)**	***NIC***	***NIC***	***NIC***
SUBTOTAL SOFT COSTS		**$788,090**	**$828,039**	**$592,785**
TOTAL PROJECT COST		**$2,442,090**	**$2,601,289**	**$1,663,785**

Dated: August 3, 2014
Austin, Texas

By: /s/ GJ
George W. Johannes, AIA

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH; *et al.*,	)	
Plaintiffs,	)	CIVIL ACTION
v.	)	CASE NO. 14-CV-284-LY
DAVID LAKEY, M.D.; *et al.*,	)	
Defendants.	)	

DIRECT TESTIMONY OF
KRISTINE HOPKINS, Ph.D.

(Filed Aug. 4, 2014)

KRISTINE HOPKINS, Ph.D., under penalty of perjury, testifies as follows:

1. I am a Research Assistant Professor at the University of Texas at Austin. My research focuses on reproductive health issues in Texas, the US-Mexico border, and Brazil. Since fall 2011, I have been co-investigator of the Texas Policy Evaluation Project, which evaluates the impact of legislation affecting reproductive health in Texas, particularly on low-income and minority women. This five-year project includes collaborators at Ibis Reproductive Health and the University of Alabama-Birmingham.

2. I received my Ph.D. in sociology with a specialization in demography from the University of

Texas at Austin in 1998. From 1998 to 2000, I worked as a postdoctoral fellow with the Population Council. From 2000 to 2001, I was a National Institute of Child Health and Human Development Postdoctoral Fellow at the Population Research Center, University of Texas at Austin. From 2001 to 2010, I served as a Research Associate at the Population Research Center, and in 2011, I was promoted to Research Assistant Professor in the Department of Sociology and the Population Research Center. I have been a Lecturer in the Department of Sociology since 2004 and in the School of Undergraduate Studies since 2012. I have taught courses in social demography, analytical demography, women's reproductive health, health and illness, and death and dying. I have authored and co-authored numerous peer-reviewed scientific journal articles in the area of women's reproductive health.

3. My curriculum vitae, which sets forth my experience and credentials more fully, is being offered as trial exhibit P-005. It contains a complete list of the publications that I have authored or co-authored.

4. I am testifying as an expert in sociology, demography, and reproductive health. My opinions are based on my education, teaching, research, and writing in the fields of sociology, demography, and reproductive health, as well as my knowledge of the literature in those fields. In addition, I relied on the data described below.

Summary of Testimony

5. To demonstrate that a large number of teens and women in the lower Rio Grande Valley and El Paso County are disadvantaged and have fewer resources to overcome barriers to accessing medical care than teens and women in other parts of Texas, my testimony shows that poverty rates for women of reproductive age (ages 15 to 44) and rates of uninsured adult women of reproductive age (ages 18 to 44) in these areas and compare them to Texas and national averages. My testimony also shows another indicator of disadvantage: birth rates for teenaged girls aged 13 to 17 for these areas as compared to Texas and a similar indicator for the US as a whole. Finally, to demonstrate that there is a demand for abortion in the lower Rio Grande Valley and El Paso County, I present data on the number of pregnancies and the number of these pregnancies that ended in abortion among women of reproductive age.

6. I present poverty rates and uninsured rates using the most recent American Community Survey 5-Year Summary File estimates (2008 to 2012). In addition, I use the most recent publicly available information on pregnancies, births, and abortions in Texas, which are from 2011.

Poverty Rates, Women 15-44

7. According to the 2008-2012 American Community Survey Summary Data File, an average of 18.9% of women aged 15 to 44 lived in poverty in the

US. Poverty is defined as living on less than 100% of the Federal Poverty Level (FPL), or $22,350 for a family of four in 2011 (source: http://aspe.hhs.gov/poverty/11poverty.shtml).The percentage of Texas's reproductive age women living in poverty during this period, 20.8%, was ten percent higher than the national average.

8. The percentage of women living in poverty in Texas during this time ranged from 0% (in two counties with fewer than 100 women of reproductive age) to 53.3% (in McMullen county, also with fewer than 100 women of reproductive age) (see Map 1). Women in the lower Rio Grande Valley had among the highest poverty rates in Texas, which ranged from 36.6% in Hidalgo County to 41.2% in Starr and Willacy counties (see Table 1). In comparison, 27% of women of reproductive age lived in poverty in El Paso County during the period, nearly 30 percent higher than the state average.

9. These percentages translate into large numbers of women of reproductive age that lived in poverty during the period: over 46,000 in El Paso County and over 100,000 in the lower Rio Grande Valley counties. That is, more than 1 in 8 women of reproductive age living in poverty in Texas lived in these five counties.

Uninsured Rates, Women 18-44

10. In 2008-2012, the percentage of adult women of reproductive age (age 18 to 44) who were uninsured in Texas was 33.6%, which was substantially higher than the national average of 21.3%. Like with poverty levels, high rates of uninsured women lived in the lower Rio Grande Valley and El Paso County (see Table 2 and Map 2). That is, over half (55.8%) of adult reproductive age women in the lower Rio Grande Valley counties and over 4 in 10 in El Paso County were without insurance.

11. These percentages translate to over 63,000 women without insurance coverage in El Paso County and over 133,000 women without insurance coverage in the Rio Grande Valley counties. Similar to the number of women living in poverty, 1 in 8 adult uninsured women of reproductive age in Texas lived in these five counties.

Teen Birth Rates in Texas

12. Compared to older mothers, girls who give birth while teenagers are less likely to complete high school and obtain a college degree, and they are also more likely to receive public assistance (National Campaign to Prevent Teen and Unplanned Pregnancy. July 2012. "Teen childbearing, education, and economic wellbeing," http://thenationalcampaign.org/resource/why-it-matters-teen-childbearing-education-and-economic-wellbeing). Teen childbearing also has negative consequences for children: compared to older

mothers, teen mothers are less likely to get timely prenatal care, and they experience higher rates of prematurity, low birthweight, and infant mortality rates. The children born to teen moms are also at higher risk of experiencing abuse and neglect and daughters of teen mothers are more likely to become teen mothers themselves (National Campaign to Prevent Teen and Unplanned Pregnancy. ND. "Teen pregnancy and overall child well-being," http://thenational campaign.org/resource/why-it-matters-teen-pregnancy-and-overall-child-wellbeing). Examining teen birth rates can therefore provide a good indication of disadvantage in a population.

13. I present information about teen birth rates for each of the 11 Department of State Health Services Health Regions rather than the county level. This is because teen births are a relatively rare event and therefore rates at the county level (especially in counties with small populations) can be unreliable. By aggregating information at the county level to the health region level, the rates are based on larger populations and are therefore more reliable.

14. The overall teen birth rate for teen girls 13 to 17 in Texas in 2011 was 15.9 per 1000 girls 13 to 17. This means that for every 1000 girls in Texas age 13 to 17, nearly 16 of them had a birth in 2011 (see Table 3). By comparison, the US teen birth rate for 15 to 17 year olds for 2011 was 15.4 (the rate for 13 to 17 year olds was not available) (source: http://www.hhs.gov/ash/oah/adolescent-health-topics/reproductive-health/states/us.html).

15. The teen birth rate in Texas ranged from a high of 25.3 per 1000 in Region 11 (home to the lower RGV) to a low of 13.1 per 1000 in Region 3 (Dallas-Fort Worth region). At 18.1 births per 1000 girls 13-17, Region 10 (home to El Paso County) had the fourth highest teen birth rate in Texas in 2011. Region 11's teen birth rate was 59% higher than the state rate for 2011, while Region 10's rate was 14% above the state rate. The above-average birth rates for teens in Regions 10 and 11 are another indicator of the disadvantage that girls 13 to 17 face in these areas.

Number of Pregnancies and Abortions in Texas and Select Counties

16. According to published data from the Department of State Health Services, there were 447,652 total pregnancies to women aged 15 to 44 reported in 2011. Of these, 69,431 were reported as ending in induced abortion (see Table 4). This number of abortions translates to 15.5% of the reported pregnancies or between 1 and 6 and 1 and 7 pregnancies that ended in induced abortion in 2011. Of the 16,140 pregnancies that were reported to residents of El Paso County, 13.5% ended in abortion (for a total of 2,182 abortions), or between 1 in 7 and 1 and 8 pregnancies. In the four counties that make up the lower Rio Grande Valley, 9.4% of pregnancies (2,619) ended in abortion. That is, 1 in every 11 pregnancies in the lower RGV ended in abortion in 2011.

Conclusion

17. The numbers of pregnancies that end in induced abortion demonstrate that there is a demand for the procedure in the lower Rio Grande Valley and El Paso County. However, given the high levels of disadvantage experienced by a large percentage of reproductive age women in the Rio Grande Valley, and to a lesser degree in El Paso County, many women in these areas who want to terminate a pregnancy would find it very difficult to travel outside the region in which they reside to access abortion care. Given the level of poverty and disadvantage that women in these areas face, the need to secure transportation and pay the costs associated with traveling outside the region amount to substantial obstacles to accessing reproductive healthcare services.

Data on Which I am Relying

Poverty rates

18. I computed poverty rates among women 15 to 44 for Texas counties, the State of Texas, and the United States. These calculations were performed using 2008-2012 American Community Survey (ACS) 5-Year Summary Files (United States Census Bureau. "Summary File." *2008-2012 American Community Survey.* U.S. Census Bureau's American Community Survey Office, 2014. Web. 6 June 2014 <http://api.census.gov/data/2012/acs5?/>). I received the data from the US Census Bureau via direct computer connection (API).

19. The ACS 5-Year Summary Files provide our nation's most robust intercensal estimate of population characteristics for specific subpopulations and specific geographical areas, particularly smaller populations like those in smaller counties. The ACS 5-Year Summary Files allow demographers to accurately describe specific demographic characteristics of specific populations.

20. For each county (and separately for Texas as a whole and the US as a whole), I summed the number of women living below 100% of the Federal Poverty Level (FPL) in each age group of reproductive age women (age groups 15, 16-17, 18-24, 25-34, 34-44). Likewise, I summed the number of women living at or above 100% of the FPL across the same age groups and then added these two groups to obtain the total number of reproductive aged women aged 15 to 44. Using these figures I then calculated the percentage of all reproductive age women living in poverty in Excel (number of reproductive age women in poverty divided by total number of women of reproductive age).

21. To create the maps of the percent poverty in each Texas county, shapefiles for Texas counties were obtained from the Texas National Resources Information System, which is part of the Texas Water Development Board and a source of high quality geodata on Texas. I merged the percent of reproductive age women in poverty by Texas county with the county geodata and generated the maps of Texas

using ArcMap. I chose categories of approximately equal size.

Uninsured rates

22. I computed rates of uninsured among women 18 to 44 for Texas counties, the State of Texas, and the US. These calculations were performed using 2008-2012 American Community Survey 5-Year Summary Files (United States Census Bureau. "Summary File." *2008-2012 American Community Survey.* U.S. Census Bureau's American Community Survey Office, 2014. Web. 6 June 2014 <http://api.census.gov/data/2012/acs5?/>). I received the data from the US Census Bureau via direct computer connection (API). In the case of insurance status by age and sex, it is not possible to distinguish 15-17 year olds from younger minors (6-14) in the data. Therefore, for uninsured rates, I approximate reproductive age women as females aged 18 to 44 rather than the customary 15 to 44.

23. For each county (and separately for Texas as a whole and the US as a whole), I summed the number of women who lacked any health insurance in each age group of adult reproductive age women (age groups: 18-24, 25-34, 34-44). Likewise, I summed the number of women who had any kind of health insurance across the age groups and then added these two groups to obtain the total number of reproductive aged women aged 18 to 44. I then computed the percentage of all reproductive age women who lacked

health insurance for each county, the state of Texas and the US as a whole. Calculations were performed in Excel.

24. As with the map of the percent of reproductive age women in poverty, shapefiles for Texas counties were obtained from the Texas National Resources Information System, which is part of the Texas Water Development Board and a source of high quality geodata on Texas. I merged the percent of reproductive age women who were uninsured by Texas county with the county geodata and generated the maps of Texas using ArcMap and chose categories of approximately equal size.

Birth rates for teen girls aged 13 to 17

25. Data on teen birth rates come from "Table 14A Reported Pregnancies, Births, Fetal Deaths, and Abortions by County of Residence for Women Age 13-17," published data from the Texas Department of State Health Services, https://www.dshs.state.tx.us/chs/vstat/vs11/t14b.shtm. I calculated the birth rates from the number of births and the number in the female population age 13 to 17 for Texas and each region and the percent above or below the overall state rate in Excel using the data supplied.

Number of pregnancies and number of abortions

26. Data on the number of pregnancies and abortions come from "Table 14A Reported Pregnancies,

Births, Fetal Deaths, and Abortions by County of Residence for Women Age 15-44," published data from the Texas Department of State Health Services, https://www.dshs.state.tx.us/chs/vstat/vs11/t14a.shtm. I calculated the percent of reported pregnancies that ended in abortion in Excel using the data supplied.

Table 1. Number of Women in Reproductive Age (15-44), Number and Percent Below 100% of the Federal Poverty Level, Texas and Selected Counties, 2008-2012

State/County	Number of Reproductive Women	Number in Poverty	Percent in Poverty
Texas	*4,154,409*	*1,093,001*	*20.8%*
El Paso	172,563	46,653	27.0%
Lower Rio Grande Valley Counties			
Hidalgo	170,688	62,423	36.6%
Cameron	85,497	32,243	37.7%
Starr	13,156	5,416	41.2%
Willacy	3,823	1,576	41.2%
Total RGV Counties	*273,164*	*103,905*	*37.2%*

Source: 2008-2012 America Community Survey 5-Year Summary File

Table 2. Number of Adult Women of Reproductive Age (18 to 44), Number and Percent Uninsured, Texas and Selected Counties, 2008-2012

State/County	Number of Reproductive Age Women	Number Uninsured	Percent Uninsured
Texas	*3,025,397*	*1,598,320*	*33.6%*
El Paso	151,409	63,531	42.0%
Lower Rio Grande Valley Counties			
Hidalgo	150,333	84,331	56.1%
Cameron	74,835	40,651	54.3%
Starr	11,385	7,025	61.7%
Willacy	3,266	1,768	54.1%
Total RGV Counties	*239,819*	*133,775*	*55.8%*

Source: 2008-2012 America Community Survey 5-Year Summary File

Table 3. Birth Rates for Teen Girls 13 to 17 Years Old for Texas and Texas' Health Service Regions, 2011

Region (main area/ cities in region)	Birth Rate*	Percent Above or Below the Overall State Rate
Texas	*15.9*	*n/a*
Region 11 (Lower Rio Grande Valley)	**25.3**	**59.4%**
Region 9 (Midland, Odessa and San Angelo)	24.1	51.7%
Region 1 (Lubbock and Amarillo)	20.8	31.0%
Region 10 (El Paso)	**18.1**	**14.1%**
Region 8 (San Antonio)	16.6	4.5%
Region 5 (Beaumont)	15.9	0.3%
Region 4 (Tyler)	16.4	3.0%
Region 2 (Wichita Falls and Abilene)	16.2	1.9%
Region 6 (Houston)	14.0	-11.9%
Region 7 (Austin and Temple)	13.6	-14.6%
Region 3 (Dallas, Fort Worth, Arlington)	13.1	-17.3%

* Birth rates per 1,000 girls 13 to 17 years of age in relevant area.

Source: Texas Department of State Health Services, https://www.dshs.state.tx.us/chs/vstat/vs11/t14b.shtm.

Table 4. Reported Pregnancies, Births, Fetal Deaths, and Abortions by County of Residence for Women Age 15-44, Texas and Selected Counties, 2011

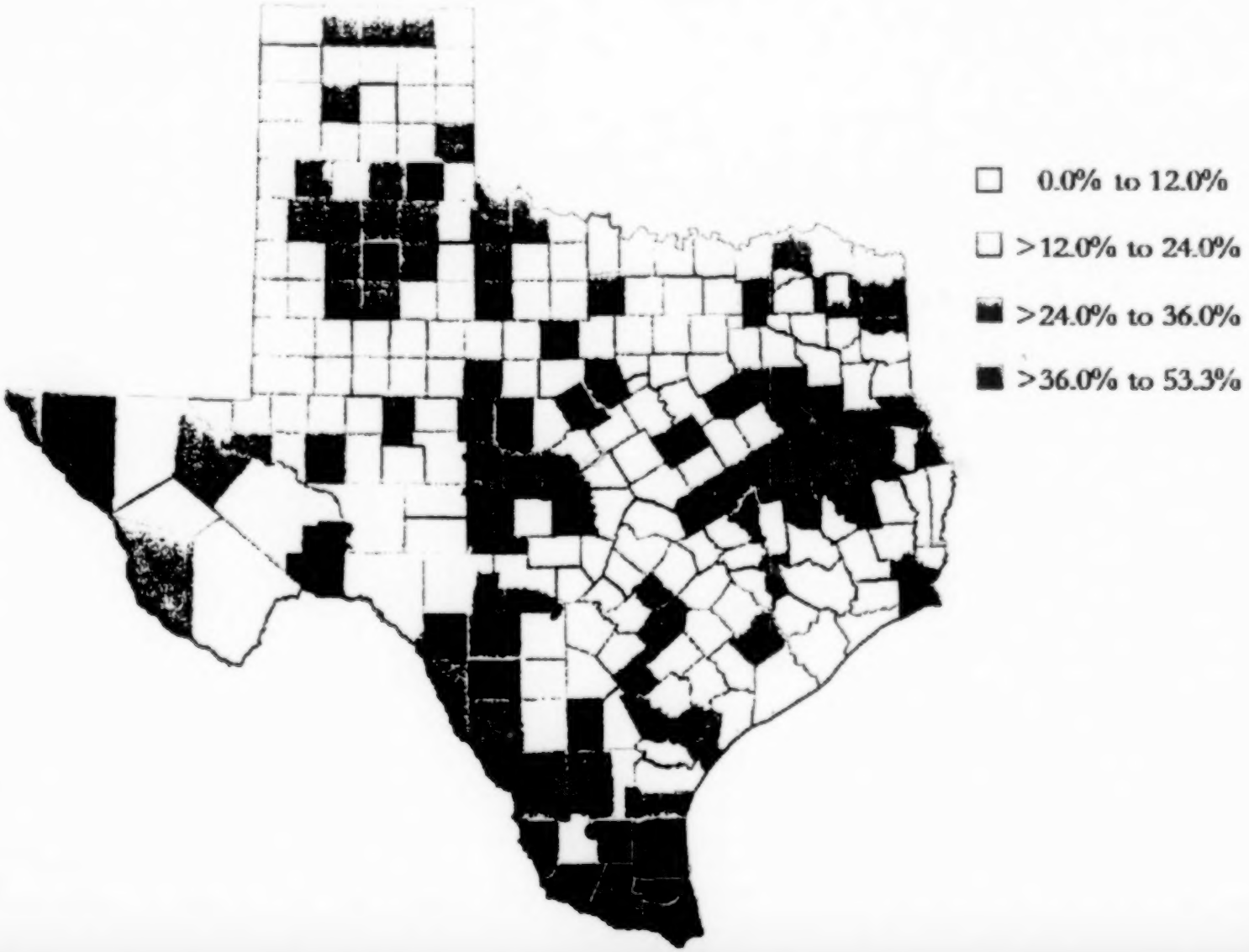
State/County	Total Pregnancies*	Live Births	Fetal Deaths	Abortions	Percent of These Reported Pregnancies that Ended in Abortion
Texas	*447,652*	*376,185*	*2,036*	*69,431+*	*15.5%*
El Paso	16,140	13,866	92	2,182	13.5%
Lower Rio Grande Valley Counties					
Hidalgo	17,851	16,051	105	1,695	9.5%
Cameron	8,342	7,523	37	782	9.4%
Starr	1,466	1,356	5	105	7.2%
Willacy	334	297	0	37	11.1%
Total RGV Counties	*27,993*	*25,227*	*147*	*4,801*	*9.4%*

* Total pregnancies equals the sum of reported live births, abortions, and fetal deaths.

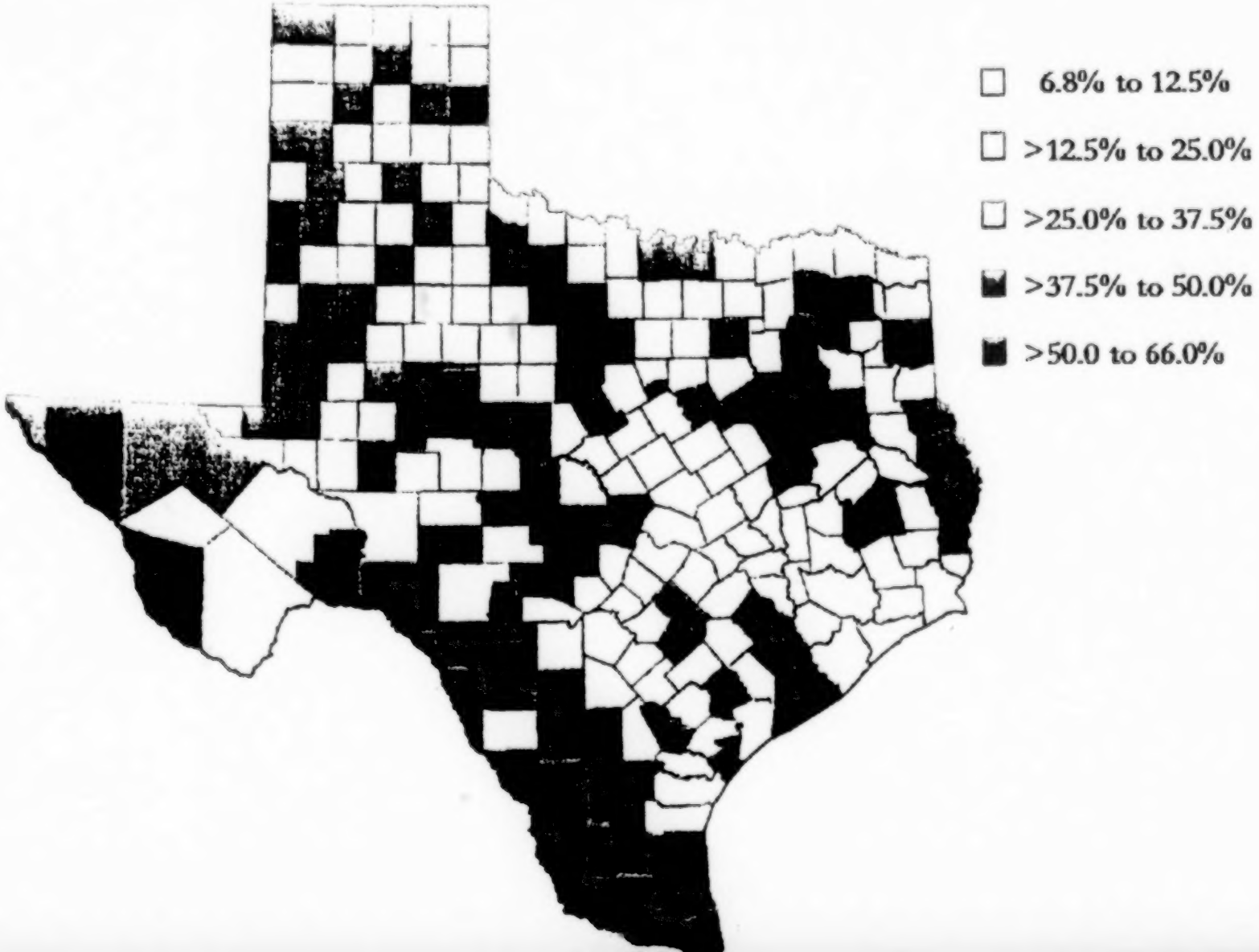
+ Includes abortions among Texas residents whose county of residence was unknown.

Source: Texas Department of State Health Services, https://www.dshs.state.tx.us/chs/vstat/vs11/t14a.shtm.

Map 1. Percent of Reproductive Age Women (15-44) below 100% of the Federal Poverty Level by Texas County, 2008-2012



Map 2. Percent of Uninsured Adult Reproductive Age Women (18-44) by Texas County, 2008-2012



Dated: August 3, 2014 By

Austin, Texas : Kristine Hopkins

Kristine Hopkins, Ph.D.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH; *et al.*,	)	
Plaintiffs,	)	CIVIL ACTION
v.	)	CASE NO. 14-CV-284-LY
DAVID LAKEY, M.D.; *et al.*,	)	
Defendants.	)	

DIRECT TESTIMONY OF
LENDOL L. ("TAD") DAVIS, M.D.

(Filed Aug. 4, 2014)

LENDOL L. ("TAD") DAVIS, M.D., under penalty of perjury, testifies as follows:

1. I am a board-certified ob-gyn and Fellow of the American College of Obstetricians and Gynecologists ("ACOG"). I am licensed to practice medicine in the State of Texas, and I have over 35 years of experience providing reproductive health care, including abortion care, to women in this State.

2. For over twenty years I provided both obstetrical care and gynecological care. In the 1990s, I retired from obstetrical practice, but I continue to offer patients a full range of gynecologic services, ranging from well-woman examinations and contraceptive services to management of menopause and

gynecologic surgery. I am certified in advanced operative laparoscopy. I also provide surgical and medical abortion care.

3. I currently serve as the Medical Director of the Austin Women's Health Center, and I served as the Medical Director of the Killeen Women's Health Center prior to its closure in June 2014. Austin Women's Health Center is, and Killeen Women's Health Center was, a licensed abortion facility and member of the National Abortion Federation ("NAF"). Together, these two facilities (collectively, the "Health Centers") have provided high-quality reproductive health services to Texas women for over 35 years.

4. I am familiar with the requirements of Texas House Bill No. 2, including the "ASC requirement," which mandates that "the minimum standards for an abortion facility must be equivalent to the minimum standards . . for ambulatory surgical centers" under Texas law.

5. Neither the Austin Women's Health Center nor the Killeen Women's Health Center meet the minimum standards for an ambulatory surgical center ("ASC") under Texas law.

6. In anticipation of the effective date of the ASC requirement, Killeen Women's Health Center ceased operations at the end of June, when it was due to pay the fee for renewal of its abortion facility license. Because the Killeen Women's Health Center would have had to cease providing abortion services as of September 1, 2014, when the ASC requirement

takes effect, the we did not renew its abortion facility license. As a result, the Killeen clinic is now closed.

7. The current facility in which the Austin Women's Health Center operates does not meet the minimum standards for ASCs under Texas law. Due to the size and shape of the lot on which it sits, it cannot be retrofitted to meet those standards.

8. Given the high level of need for abortion services in Texas, and the devastating consequences that can result when women do not have access to safe abortion care, I am doing everything in my power to be able to continue providing abortion services at the one remaining Health Center.

9. My wife and I used our retirement savings to purchase a piece of property in Austin with the aim of constructing a facility on it that meets the minimum ASC standards. We paid $1,125,000 for the property approximately two months ago. It contains an office building that currently functions as a high-end conference center that is approximately 5,000 square feet in area.

10. Prior to purchasing this property, my wife and I explored the possibility of leasing space in an existing ASC, but no ASC that we spoke to was willing to lease us space.

11. We have retained an architectural firm based in Texas that specializes in healthcare facility design to conduct a feasibility study and provide a cost estimate of converting the existing building on

the property that we purchased into an ASC. Based on initial feedback from the architects, we believed that the existing building footprint would be large enough for the ASC. But after further evaluation, the architects revised their assessment. We now understand that the ASC will have to be over 7,000 square feet to satisfy all of the standards. The revised square footage assessment provided to us by our architects is being offered as Plaintiffs' trial exhibit P-073. Our architects have also estimated that the cost of construction will be approximately $400 per square foot and have estimated the total construction cost to be approximately $3,116,000, exclusive of site development costs. We understand that this estimate may vary plus or minus 20% from the actual cost of the project. A copy of the most recent cost estimate provided to us by the architectural firm we retained is being offered as Plaintiffs' trial exhibit P-074.

12. At this time, we do not know if we will be able to move forward with construction of an ASC. We are waiting for the architectural firm to complete its feasibility study, and then we will make a decision. Given the high projected cost, we would need to obtain financing for the project. But in order to make the loan payments, we would have to raise the price of an abortion considerably, which could make it prohibitively expensive for our patients to obtain abortion care. Many of them do not have insurance coverage for abortion services.

13. Even if we do go forward with the project, we understand that construction would take at least eighteen months. We would also have to get approval from various governmental authorities for permits, and we would ultimately have to seek a license from the Department of State Health Services. Each of these steps would be time-consuming.

14. As a result, although the Austin Women's Health Center has provided high quality reproductive health care services to Texas women for over 35 years, as of September 1, 2014, it will be forced to cease providing abortion services for an indefinite period of time and possibly forever.

15. The existing facility in which Austin Women's Health Center operates has enabled it to provide safe abortion care for three and a half decades. Our abortion patients receive excellent care and experience few complications. In fact, I perform a variety of gynecological surgeries at the facility, including hysteroscopy, Novasure endometrial ablation, and dilation & curettage to treat abnormal bleeding; LEEP to treat pre-invasive cervical cancer; and hysteroscopic Essure for permanent sterilization. Some of these procedures are comparable in risk and complexity to surgical abortion, while others are actually more complex than abortion, involve older patients with higher risk factors, and/or give rise to more complications. While all of these procedures may be safely performed in an office-based setting, from a medical standpoint, it makes no sense to

single out the least risky procedure for the highest level of regulation.

Dated: August 3, 2014
Austin, Texas

By: /s/ Lendol Davis
Lendol L. ("Tad") Davis, M.D

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH; *et al.*,	)	
Plaintiffs,	)	CIVIL ACTION
v.	)	CASE NO.
DAVID LAKEY, M.D.; *et al.*,	)	14-CV-284-LY
Defendants.	)	

TESTIMONIO DIRECTO DE
LUCILA ("LUCY") CEBALLOS FELIX

(Filed Aug. 4, 2014)

LUCILA ("LUCY") CEBALLOS FELIX, ofrecerá las siguientes declaraciones como testimonio directo en el juicio en este asunto:

1. Doy mi testimonio como una experta en el acceso a servicios de salud reproductiva entre las mujeres en el Valle del Río Grande. Estoy certificada como promotora de salud y instructora por el Departamento de Servicios de Salud de Texas ("DSHS"). DSHS define promotor(a) de la siguiente manera: "Una persona que, con o sin compensación es un(a) enlace y establece la mediación cultural entre la atención sanitaria y los servicios sociales y la comunidad. Un(a) promotor(a) o trabajador(a) de salud comunitaria: es un miembro de confianza y tiene una plena comprensión de la etnia, el idioma, el

estatus socio-económico, y experiencias vividas por la comunidad atendida. Un(a) promotor(a) o trabajador(a) de salud comunitaria ayuda a las personas a tener acceso a los servicios necesarios y construye capacidad individual, comunitaria y sistematico mediante el aumento de conocimientos sobre la salud y la autosuficiencia a través de una serie de actividades tales como la divulgación de información, navegación por los pacientes y dando el seguimiento con ellos, información y educación de salud comunitaria, el asesoramiento informal, el apoyo social, promoción o abogacia, y participación en la investigación clínica. *Ver* 25 Tex Admin. Code § 146.1 (14). Esta definición describe con precisión mi papel como promotora de salud comunitaria en el Valle del Río Grande.

2. He vivido y trabajado como promotora de salud comunitaria en el Valle del Río Grande por los últimos 17 años. Actualmente, me desempeño como la Coordinadora Principal de la Red de Abogacía Latina para el Instituto Nacional Latina para Salud Reproductiva ("NLIRH"). En ese papel, yo soy la responsable en organizar aproximadamente 30 grupos comunitarios de mujeres a lo largo de los cuatro condados que forman el Valle del Río Grande. También coordino las actividades de las 77 promotoras que forman parte de la Red de Abogacía Latina/Latina Advocacy network. Yo apoyo y capacito a las promotoras, y con su ayuda, proporciono talleres educativos en materia de salud reproductiva a los grupos comunitarios aproximadamente una vez por

mes. Regularmente hablo con líderes comunitarios, funcionarios electos y trabajadores/as de salud en relación con el acceso a servicios de salud reproductiva en el Valle del Río Grande. Además de mi trabajo en el Valle del Río Grande, a veces doy capacitaciones o seminarios educativos para mujeres en San Antonio, Houston, El Paso y Corpus Christi.

3. Tengo una licenciatura en Trabajo Social del Instituto de Ciencias y Estudios de Tamaulipas (ICEST) en México. Empecé a trabajar como una promotora de salud comunitaria en el Valle del Río Grande en 1997 En ese momento, yo trabajaba para la organización AVANCE, que tiene sede en San Antonio, cuya misión es fortalecer a las familias en comunidades de alto riesgo a través de la provisión de educación y programas de apoyo a los padres de familia. Fui responsable en organizar grupos de mujeres y darles talleres de salud en Brownsville. En 2000, empecé a trabajar con la organización Migrant Health Promotion ("MHP"), donde mis responsabilidades incluyeron proporcionar talleres de salud reproductiva en todo el Valle del Río Grande. En 2003, empecé a coordinar el programa de educación de salud comunitaria del MHP, y en 2007 me converti en la Coordinadora del programa de educación, formación y promoción de la salud reproductiva, que se llamaba La Voz Latina.

4. A principios de este año, di testimonio ante el Comité de Derechos Humanos de las Naciones Unidas sobre el acceso a la salud reproductiva en el Valle del Río Grande. El Comité de Derechos Humanos es un

órgano de expertos independientes que monitorea la aplicación del Pacto Internacional de Derechos Civiles y Políticos ("ICCPR" por sus siglas en inglés) por los Estados Miembros, incluidos los Estados Unidos.

5. Durante los últimos 17 años, he trabajado con miles de mujeres en el Valle del Río Grande que buscan tener acceso a servicios de salud reproductiva. Tan sólo en 2013, trabajé con aproximadamente 500 mujeres a través de grupos de base comunitaria, talleres, cursos de formación, seminarios educativos y actividades de promoción. A través de mi trabajo como educadora de salud comunitaria, tengo discusiones directas y en persona con las mujeres del Valle del Río Grande de manera regular sobre sus necesidades de salud reproductiva. Estas discusiones se llevan a cabo tanto en entornos de grupo que de forma individual, e incluyen conversaciones sobre el estatus de empleo de una mujer, sus niños, y el acceso al transporte, ya que toda esa información es crucial para determinar cómo ayudar a una mujer obtener la atención médica que necesita. También obtengo información sobre las necesidades de la salud reproductiva de las mujeres a través de discusiones con las otras promotoras que coordino. Como resultado de ese trabajo, estoy muy familiarizada con la cultura, el idioma, el estatus socio-económico, y las experiencias de vida de la comunidad que sirvo, y hasta los desafíos que las mujeres de esa comunidad enfrentan en acceder a servicios de salud reproductiva.

La Población del Valle de Rio Grande

6. El Valle del Río Grande se compone de cuatro condados a lo largo de la frontera oriental de Texas y México: los condados de Starr, Hidalgo, Willacy y Cameron.

7. Hay algunos centros urbanos en el Rio Grande Valley—por ejemplo en McAllen, Harlingen y Brownsville—pero la gran parte de la región es rural. Las zonas rurales incluyen ciudades no incorporadas mejor conocidas como colonias, que aparecen más en el Valle del Río Grande que en cualquier otro lugar del EE.UU. Colonias pueden ser difíciles de alcanzar ya que a menudo no aparecen en el Sistema de Posicionamiento Global ("GPS") o en la aplicación de mapas de Google. En muchas colonias, los residentes tienen dificultades en acceder los servicios públicos básicos, incluyendo los sistemas de agua, electricidad, alcantarillado y calles pavimentadas.

8. La gran mayoría de las personas que viven en el Valle del Río Grande son Latinos. Muchos de ellos son nativos de habla hispana y no hablan inglés.

9. La mayoría de las mujeres con las que trabajo viven en la pobreza extrema con sus familias. Muchas viven en hogares remolque, a menudo construidos por sus propios miembros de familia con materiales que fueron encontrados por la misma área. La mayoría han tenido poca educación formal.

10. El desempleo es alto en el Valle del Río Grande, y los que están empleados suelen tener

empleos de Baja remuneración. Para mantener a sus familias, muchas mujeres sirven como trabajadoras domésticas, y prestan sus servicios de limpieza o cuidado de niños en casas de otras personas. Algunas venden comida o ropa en casa. Algunas mujeres casadas reciben apoyo económico por sus maridos, muchos de los cuales trabajan como trabajadores agrícolas migrantes. Algunas mujeres trabajan como trabajadoras agrícolas migrantes, también.

Desafíos que Las Mujeres en el Valle del Río Grande Enfrentan Para Acceder a Servicios de Salud Reproductiva

11. Las mujeres que viven en el Valle del Río Grande enfrentan muchos desafíos en el acceso a servicios de salud reproductiva en general y los servicios de aborto en particular. Estos desafíos incluyen la falta de proveedores de servicios, la falta de acceso al transporte, la necesidad de cuidado de los niños, y la incapacidad para tomar tiempo libre del trabajo.

Falta de Proveedores de Servicios

12. En general, el Valle del Río Grande está subatendido por los proveedores de salud reproductiva. Muchas mujeres dependen de clínicas de salud subvencionados por el Estado para los servicios de ginecologia y planificación familiar.

13. En 2011, el número de estas clínicas se redujo drásticamente como resultado de cambios en la

ley estatal. Pocas de ellas permanecen en el Valle del Río Grande y la demanda de sus servicios es superior a su capacidad. Como resultado, las mujeres tienen que soportar largas esperas para citas, y algunas simplemente viven demasiado lejos de la clínica más cercana para acceder a los servicios. La reducción de las clínicas ha tenido un impacto devastador en la capacidad de las mujeres para acceder a servicios de salud reproductiva preventiva, tales como pruebas de papanicolaou y los anticonceptivos de bajo costo.

14. Ahora es mucho más difícil para las mujeres en el Valle del Río Grande para evitar embarazos no deseados. Con frecuencia me encuentro con mujeres que no quieren tener más hijos pero ya no tienen acceso a metodos anticonceptivos de bajo costo y no pueden pagar el costo de un procedimiento de esterilización. Sus situaciones son trágicas y desgarradoras.

15. Los servicios de aborto también son extremadamente limitados en el Valle del Río Grande. Hasta el año pasado, había dos clínicas de aborto en la región: una en Harlingen y otra en McAllen. Ahora, debido a una nueva ley estatal que limita los proveedores de aborto, no hay ninguna.

16. Es muy lamentable que el Estado ha optado por eliminar los proveedores de aborto del Valle del Río Grande, al mismo tiempo que ha hecho recortes drásticos a las clínicas que proporcionan métodos anticonceptivos de bajo costo. Muchas mujeres en

esta región ya no tienen Buenas opciones para limitar el número de hijos que tienen.

Falta de Acceso a la Transportación

17. La falta de acceso al transporte es otra gran dificultad que enfrentan las mujeres en el Valle del Río Grande. Hay transporte publico muy limitado en la región—sólo unas pocas lineas de autobuses públicos. No todos los condados en el Valle del Río Grande son atendidos por estos autobuses, y pocas colonias se encuentran cerca de las rutas del autobús. Además, no existe transporte público que conecta el Valle del Río Grande con otras ciudades en Texas.

18. Muchas mujeres en el Valle del Río Grande no tienen automóviles propios de los cuales son dueñas. Si tienen que llegar a algún lugar que no está a una distancia que pueden llegar en pie, tienen que depender de amigas o vecinas que tienen coche y están dispuestas y disponibles a llevarlas. Además, el costo de la gasolina es un problema para muchas mujeres. Estas mujeres no pueden darse el lujo de tomar un largo viaje en coche—ya sea en su propio coche o el de otra persona—porque la gasolina necesaria para poder llegar en coche es demasiado cara. El costo de la gasolina es a menudo un elemento de disuasión para las mujeres que desean viajar dentro del Valle del Río Grande.

19. Las mujeres que trabajan fuera de casa suelen caminar a trabajar u organizar los carros para compartir los gastos asociados en llevar un carro.

20. No es raro que una mujer pierda una cita médica a causa de transporte poco fiable o inexistente.

Necesidad de Cuido de Niños

21. En el Valle del Río Grande, la mayoría de las mujeres de edad reproductiva tienen hijos a su cargo, y las mujeres casi siempre son las principales cuidadoras de sus hijos.

22. Tener hijos hace que sea más difícil para poder asistir a las citas medicos. Una mujer tiene que llevar sus hijos con ella a atenderse en un centro de salud o encontrar a alguien que se los cuide mientras está fuera en la cita. Si una mujer lleva a sus hijos con ella a un centro de salud, tiene que hacer los arreglos para el transporte tanto para ella como para sus hijos. Esto limita las opciones de compartir el viaje e implica costos adicionales para la tarifa de autobús o la gasolina. Por otro lado, encontrar a alguien para cuidar a los niños también pueden surgir gastos adicionales y limitar la flexibilidad para programar una cita.

Incapacidad de Tomar Tiempo Libre del Trabajo

23. Dadas las altas tasas de desempleo y pobreza en el Valle del Río Grande, las mujeres que

trabajan fuera del hogar son cautelosas en cuanto a tomar tiempo libre del trabajo y potencialmente poner en peligro su empleo. Las mujeres no se atreven a it a las citas médicas si eso significa que tienen que tomar tiempo libre de su trabajo. En lugar de ello, algunas mujeres sacrifican no recibir atención médica, aun cuando se sienten enferma o tienen una condición médica que requiere tratamiento, para evitar poner su empleo en riesgo

Impacto de los Cierres de la Clínicas de Servicios de Aborto

24. Como resultado de una ley promulgada el año pasado que requiere que los proveedores de abortos tengan privilegios de admisión en un hospital local, ambas clínicas que fueron autorizadas para proveer servicios de aborto en el Valle del Río Grande han cerrado. Con el reciente cierre de la clínica de aborto en Corpus Christi, la clínica de aborto autorizada más cercana al Valle del Río Grande ahora está en San Antonio. Desde McAllen, que se encuentra cerca del centro del Valle del Río Grande, San Antonio es más de 235 kilómetros de distancia.

25. Con respecto a las mujeres en el Valle del Río Grande que actualmente buscan el acceso a los servicios de aborto, algunas no se yen afectadas por los cierres de clínicas de aborto porque no hubieron sido capaces de acceder a los servicios de aborto, incluso si esas clínicas seguían abiertas. Esas mujeres estaban en una situación calamitosa antes y

permanecen en una situación desesperada ahora. Pero para las mujeres que se yen afectadas, las que hubieran podido tener acceso a los servicios de aborto en McAllen o Harlingen—el cierre de la clínica impone un gran obstáculo para su acceso a los servicios de aborto. Estas mujeres ya no pueden tener acceso a servicios de aborto a menos que puedan viajar a San Antonio o más lejos. Basado en mi experiencia trabajando con estas mujeres como una promotora de salud desde hace casi dos decadas, creo que una gran proporción de ellas no sera capaz de hacerlo.

26. Los desafíos para acceder a servicios de salud reproductiva descritos antes aumentan con la distancia que una mujer debe recorrer para llegar a un proveedor de servicios. Por ejemplo, la disponibilidad de las disminuciones de transporte y el costo de los aumentos de transporte con la duración del viaje. Un aumento de más de 470 millas es muy significativo para una mujer en el Valle del Río Grande. No hay transporte público que va entre el Valle del Río Grande y San Antonio, y es a través de una unidad de 3,5 horas en cads dirección. Eso equivale a un minimo de 7 horas de tiempo de viaje. Los costos de la gasolina son significativamente más altos que si una mujer sólo tenia que viajar por el Valle del Río Grande, y es más difícil para una mujer sin un coche encontrar a alguien dispuesto y capaz de conducir a ella. (Si una mujer va a una clínica en McAllen, una amiga o una vecina podría dejarla, volver a casa, y luego recogerla cuando terminó. Pero

San Antonio está demasiado lejos para eso. El conductor tiene que comprometerse a acompafiarla para todo el día.)

27. Si una mujer fuera a tomar un autobús Greyhound desde McAllen a San Antonio, el viaje tomaría entre 4 y 5 horas por ida o por vuelta, y los tiempos de viaje son limitados. Un boleto de autobús desde McAllen a San Antonio puede costar hasta $75, dependiendo de la temporada, lo cual es un gasto grande para una mujer que vive en la pobreza, en particular cuando afiade el costo del procedimiento de aborto. Para algunas mujeres les tomaría mucho tiempo para ahorrar ese dinero adicional. Los boletos de autobús a veces son más baratos si se compran en linea, pero muchos residentes de la región no tienen acceso al Internet.

28. Las dificultades asociadas con el cuidado de niños también aumentan con la distancia. Si una mujer lleva a sus hijos con ella a la clínica, ella tiene que pagar mayores gastos de viaje para ellos de lo que de otra forma sería y tiene que hacerse cargo de sus necesidades, tales como el comer, dormir la siesta, y/o roturas de baño durante todo el viaje. Si los deja en casa, ella tiene que hacer arreglos para el cuidado de niños durante 7 - 10 horas adicionales (dependiendo de su modo de transporte), que es más difícil y más caro.

29. Las mujeres que trabajan fuera del hogar también enfrentan dificultades significativamente mayor. En lugar de tener que tomar un par de horas

fuera del trabajo, una mujer ahora tiene que tomar un día libre entero del trabajo para visitar una clínica de aborto.

30. La auto-inducción del aborto ya era practicado por las mujeres del Valle del Río Grande quienes estaban desesperadas por poner fin a un embarazo, pero que no tenían los medios para obtener servicios de aborto en una clínica con licencia. Las mujeres usan una variedad de métodos para tratar de auto-abortar, incluyendo los remedios caseros, como infusions de té y medicamentos comprados en el mercado negro. Muchas mujeres son conscientes de que el misoprostol se puede utilizar para inducir un aborto. Este medicamento se puede adquirir sin receta médica en México y es ampliamente traficada en el Valle del Río Grande, que colinda con la frontera de México.

31. Al igual que cualquier medicamento obtenido en el mercado negro, el misoprostol obtenido de esta manera puede ser falsificado, inadecuado para las necesidades médicas de una mujer en particular, o usado incorrectamente porque una mujer no tiene la infonnación adecuada. Además, dada la escasez general de los proveedores de salud en la región, si surge una complicación o emergencia médica, puede que una mujer no pueda acceder la atención medica que ella necesita para resolverlo. Como promotora de salud comunitaria, me preocupa profundamente que las mujeres de mi comunidad se verán dañadas por los intentos de autoinducir el aborto.

32. Dado que las clínicas de aborto en el Valle del Río Grande cerraron, un número de mujeres cads vez mayor han intentando auto-abortar. A través de mi trabajo como promotora, me he reunido con algunas de estas mujeres y he oído sus historias. Ellas estan enfrentando a una situación desesperada, y no pueden viajar cientos de kilómetros al norte para acceder a servicios de aborto legal en San Antonio. En lugar de ello, cruzan la frontera a México para obtener misoprostol o compran la sustancia en el mercado negro en Texas.

Fecha: 1 Agosto 2014
Austin, Texas

By: /s/ Lucy Ceballos
Lucila ("Lucy") Ceballos Felix

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH; *et al.*,	)	
Plaintiffs,	)	CIVIL ACTION
v.	)	CASE NO. 14-CV-284-LY
DAVID LAKEY, M.D.; *et al.*,	)	
Defendants.	)	

DIRECT TESTIMONY OF
LUCILA ("LUCY") CEBALLOS FELIX

LUCILA ("LUCY") CEBALLOS FELIX, will offer the following statements as direct testimony at the trial in this matter:

1. I am testifying as an expert on access to reproductive healthcare services among women in the Rio Grande Valley. I am certified as a *promotora* or community health worker and instructor by the Texas Department of State Health Services ("DSHS"). DSHS defines promotor(a) as follows: "A person who, with or without compensation is a liaison and provides cultural mediation between health care and social services, and the community. A promotor(a) or community health worker: is a trusted member, and has a close understanding of, the ethnicity, language, socio-economic status, and life experiences of the community served. A promotor(a) or community

health worker assists people to gain access to needed services and builds individual, community, and system capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, patient navigation and follow-up, community health education and information, informal counseling, social support, advocacy, and participation in clinical research." *See* 25 Tex. Admin. Code S 146.1(14). This definition accurately describes my role as a community health educator in the Rio Grande Valley.

2. I have lived and worked as a community health educator in the Rio Grande Valley for the past 17 years. Currently, I serve as the Texas Latina Advocacy Network Field Lead Coordinator for the National Latina Institute for Reproductive Health ("NLIRH"). In that role, I am responsible for organizing approximately 30 community-based groups of women throughout the four counties that constitute the Rio Grande Valley. I also coordinate the activities of 77 *promotoras* who are part of the *Red de Abogacia Latina*/Latina Advocacy Network. I support and train the *promotoras*, and with their help, I provide educational workshops concerning reproductive health to community-based groups approximately once per month. On a regular basis, I speak to community leaders, elected officials, and health workers concerning access to reproductive healthcare services in the Rio Grande Valley. In addition to my work in the Rio Grande Valley, I sometimes provide training or

educational seminars to women in San Antonio, Houston, El Paso and Corpus Christi.

3. I hold a Bachelors degree in Social Work from the Institute of Science and Studies of Tamaulipas (ICEST) in Mexico. I began working as a community health educator in the Rio Grande Valley in 1997. At that time, I worked for the San Antonio-based organization AVANCE, whose mission is to strengthen families in at-risk communities through effective parent education and support programs. I was responsible for organizing groups of women and giving health workshops in Brownsville. In 2000, I began working with the organization Migrant Health Promotion (MHP), where my responsibilities included providing reproductive health workshops throughout the Rio Grande Valley. In 2003, I began coordinating MHP's community health education program, and in 2007 I became the Coordinator for its reproductive health education, training and advocacy program, *La Voz Latina*.

4. Earlier this year, I testified before the United Nation's Human Rights Committee on access to reproductive healthcare in the Rio Grande Valley. The Human Rights Committee is a body of independent experts that monitors implementation of the International Covenant on Civil and Political Rights ("ICCPR") by State parties, including the United States.

5. Over the past 17 years, I have worked with thousands of women in the Rio Grande Valley seeking

to access reproductive healthcare services. In 2013 alone, I worked with approximately 500 women through community-based groups, workshops, trainings, educational seminars and advocacy activities. Through my work as a community health educator, I have direct, face-to-face discussions with women in the Rio Grande Valley about their reproductive healthcare needs on a regular basis. These discussions take place both in group settings and individually, and include conversations about a woman's employment status, children, and access to transportation because that information is crucial to me determining how to help the woman obtain the healthcare that she needs. I also obtain information about women's reproductive healthcare needs from discussions with the promotoras that I coordinate. As a result, I am thoroughly familiar with the culture, language, socio-economic status, and life experiences of the community that I serve, as well as with the challenges women in that community face in accessing reproductive healthcare services.

The Rio Grande Valley's Population

6. The Rio Grande Valley is comprised of four counties along the eastern border of Texas and Mexico: Starr County, Hidalgo County, Willacy County, and Cameron County.

7 There are some urban centers in the Rio Grande Valley—for example, in McAllen, Harlingen, and Brownsville—but much of the region is rural.

The rural areas include unincorporated towns known as *colonias*, which are more prevalent in the Rio Grande Valley than anywhere else in the United States. *Colonias* can be hard to reach because they often do not appear on Global Positioning System ("GPS") maps or in Google's mapping application. In many *colonias*, residents have a difficult time accessing basic public services, including water, electricity, sewage and drainage systems, and paved roads.

8. The vast majority of people living in the Rio Grande Valley are Latino. Many are native Spanish speakers who do not speak English.

9. The majority of the women with whom I work live in extreme poverty with their families. Many live in ad hoc trailer homes, often built by their own family members with materials they were able to find locally. Most have had little formal education.

10. Unemployment is high in the Rio Grande Valley, and those who are employed typically have low-wage jobs. To support their families, many women serve as domestic workers, providing cleaning or childcare services in other people's homes. Some sell homemade food or clothes. Some married women are supported by their husbands, many of whom work as migrant farm laborers. Some women also work as migrant farm laborers.

Challenges Women in the Rio Grande Valley Face in Accessing Reproductive Healthcare Services

11. Women living in the Rio Grande Valley face many challenges in accessing reproductive health care services generally and abortion care specifically. These challenges include lack of service providers, lack of access to transportation, need for childcare, and inability to take time off from work.

Lack of Service Providers

12. In general, the Rio Grande Valley is underserved by reproductive health care providers. Many women rely on State-subsidized health clinics for gynecological and family planning services.

13. In 2011, the number of these clinics was dramatically reduced as a result of changes in State law. Few of them remain in the Rio Grande Valley and demand for their services exceeds their capacity. As a result, women must endure long waits for appointments, and some simply live too far from the nearest clinic to access services. The reduction in clinics has had a devastating impact on women's ability to access preventative reproductive health care, such as pap smears and affordable contraceptives.

14. It is now much harder for women in the Rio Grande Valley to avoid unwanted pregnancies. I frequently encounter women who do not want to have additional children but no longer have access to

affordable contraceptives and cannot afford the cost of a sterilization procedure.

15. Abortion services are also extremely limited in the Rio Grande Valley. Until last year, there were two abortion clinics in the region: one in Harlingen and one in McAllen. Now, because of a new State law limiting abortion providers, there are none.

16. Increasing the hardship for these women, the closure of all abortion providers in the Rio Grande Valley is occurring at the same time that the State has made drastic cuts to clinics that provide affordable contraception. Many women in this region now have no good options for limiting the number of children that they have.

Lack of Access to Transportation

17 Lack of access to transportation is another huge difficulty facing women in the Rio Grande Valley. There is very limited public transportation in the region—just a few public bus lines. Not all of the counties in the Rio Grande Valley are served by these buses, and few *colonias* are located near bus routes. Further, there is no means of public transportation that connects the Rio Grande Valley with other cities in Texas.

18. Many women in the Rio Grande Valley do not own cars. If they need to get somewhere that is not in walking distance, they must depend on friends or neighbors who do own cars and are willing and

available to drive them somewhere. In addition, the cost of gasoline is an issue for many women. These women cannot afford to take long car trips—whether in their own car or somebody else's—because the gasoline needed to fuel the car is too expensive. The cost of gasoline is often a deterrent for women seeking to travel within the Rio Grande Valley.

19. Women who work outside the home often walk to work or organize car pools to spread the expenses around.

20. It is not uncommon for a woman to miss a medical appointment because of unreliable or unavailable transportation.

Need for Childcare

21. In the Rio Grande Valley, most women of reproductive age have dependent children, and women are almost always the primary caretakers for their children.

22. Having children makes it harder to attend medical appointments. A woman must either bring her children with her to the healthcare facility or find someone to care for the children while she is away. If a woman brings her children with her to a healthcare facility, she must arrange for transportation that will accommodate her as well as her children. This limits carpool options and entails additional costs for bus fare or gasoline. On the other hand, finding someone

to care for the children also entails additional costs and limits flexibility for scheduling an appointment.

Inability to Take Time off from Work

23. Given the high rates of unemployment and poverty in the Rio Grande Valley, women who are employed outside of the home are cautious about taking time off from work and potentially jeopardizing their employment. Based on my experience, women are hesitant to go to medical appointments if it means they have to take time off of work. Instead, some women will forgo medical treatment, even when they feel ill or have a medical condition that needs treatment, to avoid putting their employment at risk.

Impact of the Abortion Clinic Closures

24. As a result of recent changes in State law, both clinics that were licensed to provide abortion services in the Rio Grande Valley have closed. With the recent closure of the abortion clinic in Corpus Christi, the closest licensed abortion clinic to the Rio Grande Valley is now in San Antonio. From McAllen, which is located near the center of the Rio Grande Valley, San Antonio is more than 235 miles away.

25. With respect to women in the Rio Grande Valley who are currently seeking access to abortion services, some are not impacted by the abortion clinic closures because they would not have been able to access abortion services even if those clinics were still

open. Those women were in a dire situation before and remain in a dire situation now. But for the women who are affected—those who would have been able to access abortion services in McAllen or Harlingen—the clinic closures pose a huge obstacle to their ability to access abortion services. These women can no longer access abortion services unless they can travel to San Antonio or farther. Based on my experience working with these women as a community health educator for nearly two decades, I believe that a large proportion of them will be unable to do so.

26. The challenges to accessing reproductive healthcare services described above increase with the distance that a woman must travel to reach a service provider. For example, the availability of transportation decreases and the cost of transportation increases with the length of the journey. An increase of over 470 miles round-trip is incredibly significant for a woman in the Rio Grande Valley. There is no public transportation that goes between the Rio Grande Valley and San Antonio, and it is over a 3.5 hour drive each way. That amounts to a minimum of 7 hours of travel time. Gasoline costs are significantly higher than if a woman only had to travel within the Rio Grande Valley, and it is harder for a woman without a car to find someone willing and able to drive her. (If a woman were going to a clinic in McAllen, a friend or neighbor could drop her off, return home, and then pick her up when she was done. But San Antonio is too far away for that. The

driver must commit to accompanying her for the whole day.)

27. If a woman were to take a Greyhound bus from McAllen to San Antonio, the trip would take between 4 and 5 hours each way, and travel times are limited. A bus ticket from McAllen to San Antonio may cost up to $75, depending on the season, which is a large expense for a woman living in poverty, particularly when layered on top of the cost of the abortion procedure itself. It would take some women quite a long time to save up that additional money. Bus tickets are sometimes cheaper if you buy them online, but many people in the region do not have access to the internet. For these reasons, I do not know of any women living in poverty in the Rio Grande Valley who travel to San Antonio by commercial bus.

28. The difficulties associated with childcare also increase with distance. If a woman brings her children with her to the clinic, she has to pay greater travel expenses for them than she otherwise would and has to take care of their needs—including eating, napping, and/or bathroom breaks—throughout the journey. If she leaves them at home, she needs to arrange for childcare for an additional 7-10 hours (depending on her mode of transportation), which is more difficult and more expensive.

29. Women who work outside the home also face significantly increased difficulties. Instead of needing to take a few hours off from work, a woman now

needs to take a full day off from work to visit an abortion clinic.

30. Self-abortion was already practiced by women in the Rio Grande Valley who are desperate to end a pregnancy but do not have the means to obtain abortion services at a licensed clinic. Women use a variety of methods to attempt self-abortion, including home remedies, like herbal teas, and medications purchased on the black market. Many women are aware that misoprostol can be used to induce an abortion. This medication is available over-the-counter in Mexico and is widely trafficked in the Rio Grande Valley, which borders Mexico.

31. Like any medication obtained on the black market, misoprostol obtained in this way can be counterfeit, inappropriate for a particular woman's medical needs, or used incorrectly because a woman does not have adequate information. Moreover, given the overall shortage of healthcare providers in the region, should a complication or medical emergency arise, a woman may not be able to access the care that she needs to resolve it. As a community health educator, I am deeply concerned that women in my community will be harmed by attempts at self-inducing abortion.

32. Since the abortion clinics in the Rio Grande Valley closed, an increasing number of women have been attempting self-abortion. Through my work as a *promotora*, I have met with some of these women and heard their stories. They are facing desperate

circumstances, and are unable to travel hundreds of miles north to access legal abortion services in San Antonio. Instead, they cross the border to Mexico to obtain misoprostol or buy the substance on the black market in Texas.

Dated: August 3, 2014
Austin, Texas

By: /s/ Lucy Ceballos
Lucila ("Lucy") Ceballos Felix

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH; *et al.*,	)	
Plaintiffs,	)	CIVIL ACTION
v.	)	CASE NO. 14-CV-284-LY
GREGORY ABBOTT; *et al.*,	)	
Defendants.	)	

DIRECT TESTIMONY OF PAUL M. FINE, M.D.

(Filed Aug. 4, 2014)

PAUL M. FINE, M.D., under penalty of perjury, testifies as follows:

1. I am board-certified in obstetrics and gynecology and a Fellow of the American Congress of Obstetricians & Gynecologists ("ACOG"). I am a Professor in the Departments of Obstetrics & Gynecology and Urology at the Baylor College of Medicine in Houston, where I have been on the faculty since 1979. I am the Medical Director of Planned Parenthood Gulf Coast and Planned Parenthood Center for Choice, Inc. I am also the Medical Director of Emergency Medical Services ("EMS") for three cities in Galveston County, Texas. In addition, I have written or co-authored more than 40 peer-reviewed publications, including publications concerning abortion. My curriculum vitae, which sets forth my experience and credentials more fully, is offered as Exhibit

P-006. It contains a complete list of the publications that I have authored or co-authored.

2. I have over four decades of experience providing abortions, teaching abortion methods, and supervising the provision of abortion services in hospital and outpatient settings. This experience includes both community private practice and urban medical center environments. I have been on staff at approximately twelve hospitals. I also treat and teach about the treatment of the complications that can occur after abortion, which are rare.

3. I am testifying as an expert in obstetrics and gynecology; the provision of abortion services; the treatment of abortion complications; and general emergency medical services and transfers. My opinions are based on my years of experience in the field of obstetrics and gynecology; my teaching, clinical, and research experience in abortion care; my involvement in the provision of emergency medical services; and my review of the relevant medical and scientific literature, including the specific sources cited in this report.

4. I am familiar with the requirements of Texas House Bill No. 2, including the "admitting privileges requirement," which mandates that all physicians who provide abortion services "have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced," and the "ASC requirement," which mandates that "the minimum standards for an

abortion facility must be equivalent to the minimum standards . . . for ambulatory surgical centers" under Texas law.

5. Good medical practice requires that health-care decisions be made on the basis of reliable evidence. Both the admitting privileges requirement and the ASC requirement depart from accepted medical practice, and no reliable evidence supports the claim that these requirements will enhance the safety of abortion procedures or promote women's health. To the contrary, overwhelming evidence indicates that, by reducing the number and geographic distribution of abortion providers in Texas, these requirements will put the health of women seeking abortions at risk.

Abortion Methods and Their Safety

6. Roughly 90 percent of all abortions performed in the United States occur during the first trimester of pregnancy (up to 13.6 weeks of pregnancy as measured from the first day of a woman's last menstrual period, or "LMP") and almost two-thirds (61 percent) occur at eight weeks LMP or less. Moreover, very early abortions (6 weeks LMP or less) have become more prevalent, essentially doubling from 14 percent of all abortions in 1992 to 30 percent in 2006.[1]

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[1] Pazol Karen et al., Centers for Disease Control and Prevention (CDC), Abortion surveillance—United States, 2006. *Morbidity and Mortality Weekly Report 1-35.* 2009; 58 (P-081);

(Continued on following page)

7. In general, two methods of performing abortions are used in the United States: surgical abortion and medical abortion.

8. Surgical abortion involves the use of instruments to evacuate the contents of the uterus. Despite the term "surgical," this method of abortion involves no incision or suturing. Instead, it entails insertion of instruments into a body cavity (the uterus) through a natural orifice (the vagina). In this respect, it is analogous to the insertion of a catheter into the bladder.

9. The procedure is typically performed in a room with an examination table, on which the patient will lie on her back with her hips and knees flexed and thighs apart in the lithotomy position, most often with her feet or legs in stirrups similar to a routine gynecological examination. After adequate dilation of the patient's cervix, the physician will insert a suction cannula or other instrument through her vagina and cervix into her uterus to empty its contents. The procedure is short in duration, typically lasting two to ten minutes.

10. Surgical abortions performed in the first trimester and early second trimester generally do not entail the use of general anesthesia. A local anesthetic is typically applied to the cervix, sometimes in

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Gamble Sonya *et al.*, CDC, Abortion surveillance—United States, 2005. *Morbidity and Mortality Weekly Report.* 57: 1-32 (2008).

tandem with minimal or moderate sedation. Generally, procedures performed under general anesthesia are riskier, more invasive, and more complex than those performed under lesser forms of analgesia.

11. Surgical abortion is analogous to other gynecological procedures in terms of risks, invasiveness, instrumentation, and duration. For example, first-trimester surgical abortions are nearly identical to diagnostic or therapeutic dilation and curettage ("D&C") on a non-pregnant woman and surgical completion of spontaneous miscarriage; both of these procedures involve dilating the cervix and evacuating the uterus with instruments. Surgical abortion is also comparable to non-gynecological surgical procedures in terms of risk, invasiveness, instrumentation, and duration. For example, abortion is comparable in these respects to colonoscopy with removal of polyps, as well as cystoscopy, which entails looking into the bladder with a telescope.

12. Medical abortion involves the use of medications to terminate a pregnancy. The medications most commonly used for this purpose are mifepristone and misoprostol. Mifepristone (also known as "RU-486" or by its trade name, Mifeprex) terminates a pregnancy by blocking progesterone, a naturally produced hormone that prepares the lining of the uterus for a fertilized egg and helps maintain pregnancy. Without progesterone, the pregnancy cannot continue; the lining of the uterus softens and breaks down, and the embryo detaches from the uterine lining. Misoprostol (also known as a prostaglandin or by its trade name,

Cytotec) causes the uterus to contract and expel the embryo or fetus and other products of conception.

13. In the United States, clinicians typically use these medications in tandem to induce an abortion, but misoprostol can also be used on its own for that purpose, although it is less effective when used alone. In Texas, these medications are administered orally.

14. These same medications are offered as a treatment option to women who have a spontaneous miscarriage with retained tissue.

15. Medical abortion requires no anesthesia or sedation. Over-the-counter medication is sufficient to alleviate any pain associated with medical abortion.

16. Overall, abortion is an extremely safe procedure, and abortion-related complications are rare. The types of complications that may occur following a medical abortion include retained tissue, bleeding, and infection. The types of complications that may occur following a surgical abortion include the foregoing ones as well as uterine perforation. Bleeding after an abortion is not always a sign of a complication, because some bleeding is expected after both surgical and medical abortions.

17. Because the risk of complications from abortion is so low, over 90% of abortions in the United States are performed in outpatient settings rather

than in hospitals.[2] The vast majority of these are performed in office-based settings (*i.e.*, doctors' offices and specialized clinics) rather than in ambulatory surgery centers ("ASCs").

18. Many other procedures that are typically performed in office-based settings are more complex and invasive than abortion. These include hysteroscopy, endometrial ablation, loop electrical excision of precancerous cervical lesions (LEEP), colonoscopy, and wide excisions of skin cancers.

The Admitting Privileges Requirement Departs from Accepted Medical Practice and Does Not Enhance the Safety of Abortion Care

19. The admitting privileges requirement departs from accepted medical practice. Both the nation's leading medical association (the American Medical Association or "AMA"), and the nation's leading association of obstetricians and gynecologists (the American Congress of Obstetricians and Gynecologists or "ACOG") maintain that "there is no medically sound basis for H.B. 2's privileges requirement."[3] Further, the professional standards of ACOG,

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[2] Jones RK, Jerman J. Abortion incidence and service availability in the United States, 2011. Perspect Sex Reprod Health. 2014 Mar;46(1):3-14.

[3] Amicus Brief at 2, *Planned Parenthood of Greater Tex. Surgical Health Serv. v. Abbott*, 748 F.3d 583 (5th Cir.) (No. 13-51008); *see also Statement on State Legislation Requiring Admitting Privileges for Physicians Providing Abortion Services*,

(Continued on following page)

Planned Parenthood Federation of America ("PPFA"), and the National Abortion Federation ("NAF"), while recognizing that clinics that perform abortions should have arrangements in place for transferring patients who require emergency treatment, do not require that physicians providing abortion services at those clinics have hospital admitting privileges.[4]

20. The trend in medicine today is toward specialization of physicians who practice in out-patient settings and physicians who practice in hospitals.

21. Most hospitals have their own dedicated staff physicians. These "hospitalists" often provide only inpatient care. For example, obstetrician hospitalists, called "laborists," provide inpatient obstetric care during delivery, while a community obstetrician

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ACOG, Apr. 25, 2013, *available at* http://www.acog.org/About_ACOG/News_Room/News_Releases/2013/Hospital_Admitting_Privileges_for_Physicians_Providing_Abortion_Services; ACOG, Analysis of the Possible FDA Mifepristone Restrictions (July 27, 2000) at 3.

[4] American College of Obstetricians and Gynecologists. Guidelines for Women's Health Care: A Resource Manual. 3rd ed. Washington, DC: American College of Obstetricians and Gynecologists; 2007 (P-192); National Abortion Federation. 2013 Clinical Policy Guidelines. Dec. 2012; 55; PPFA Manual of Medical Standards & Guidelines. Clinical Program Structure I-A-1. June 2012; 12.

provides prenatal care and treats the pregnant woman as an outpatient.[5]

22. Even where a hospital's staff physicians are not solely hospitalists, if a pregnant woman experiences a complication, like pre-eclampsia or preterm labor, that requires emergency care, she will often be cared for in the hospital by the physician specialist on call and not her regular physician.

23. It is extremely common for physicians to cover for each other and refer to other physicians as necessary to treat a patient. It is also well understood in medicine that, for a physician to be properly trained and qualified to perform the procedures he or she performs, he or she need not be trained and qualified to handle all of the potential consequences and complications of those procedures. All physicians, at some point, must (and should) refer their patients to another specialist, or a subspecialist, to ensure quality of care. A good example of this is the gastroenterologist who regularly performs colonoscopy and polyp removal in an outpatient setting. Complications from colonoscopy such as bleeding or perforation must be managed by a colorectal surgeon and not the gastroenterologist, and this must be done in a hospital setting.

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[5] The Role of Laborist in Patient Care, available at http://www.oblaborist.org/ (last visited June 13, 2014).

24. Referring a patient to an emergency room to manage complications that arise from outpatient procedures is common in medicine even outside the abortion context. I treat patients who have come to our hospital because of complications from a variety of gynecological surgeries performed in outpatient settings, and we provide high quality care to those patients regardless of whether the surgeon who performed the procedure has admitting privileges. For example, hysteroscopy and diagnostic dilation and curettage on nonpregnant women and surgical management of spontaneous miscarriage are frequently performed in outpatient settings. If there are complications, such as a uterine perforation, during such a procedure, the patient will be transferred to the hospital ER and may need follow-up surgery.

25. Similarly, there has been an increase in physicians' use of anesthesia, even general anesthesia, in outpatient settings. Complications from general anesthesia are much more common than complications from abortion. When patients experiencing those complications are transferred to the ER, the quality of care they receive there is not related to whether the physician who performs the outpatient procedure or administers the anesthesia has admitting privileges at the hospital.

26. In light of the foregoing, it is not surprising that no reliable evidence supports the contention that the admitting privileges requirement enhances the safety of abortion.

27. Most of the complications associated with abortion can be appropriately and safely managed by monitoring and/or treating the patient in an office-based setting. For example, most cases of non-severe hemorrhage are managed in the clinic with uterotonic medications that increase the tone of the uterine muscle causing the uterus to contract and reduce bleeding. Women with mild infections are usually treated on an outpatient basis with oral and/or injected antibiotics. In the case of a missed abortion or an incomplete abortion with retained tissue, the physician can provide the necessary follow-up treatment, which may involve administration of medicine or re-aspiration, in the outpatient clinic.

28. It is extremely unlikely that a patient will experience a serious complication at the clinic that requires emergent hospitalization. But in the rare case in which the patient needs to be transferred by ambulance to a hospital, the quality of care that the patient receives is not affected by whether the abortion provider has admitting privileges at the hospital. An emergency room physician will decide if it is necessary to involve an ob/gyn in the patient's care, and if so, he or she will contact the ob/gyn on call at that hospital, who can admit the patient if necessary. All ob/gyns, regardless of whether they perform abortions, are qualified to manage the care of a patient experiencing a complication from an abortion, and to refer the patient, where necessary, to the appropriate subspecialist. Continuity of care can be maintained by direct telephone communication

between the abortion provider and the emergency room physician; it is not dependent on whether the abortion provider has admitting privileges. Such direct telephone contact is standard medical practice and serves to ensure that the emergency room physician is aware of the extent of the complication, prior treatment, and medication received. Additionally it is standard procedure to send a copy of the patient's medical records with the patient being transferred to a hospital by ambulance.

29. Even if the abortion provider has privileges at a local hospital, the provider often has little ability to control where the Emergency Medical Technicians ("EMTs") take the patient. EMTs must follow EMS protocols, which typically require the patient to be transferred to the nearest hospital that is accepting patients.

30. The distances some women travel to obtain an abortion render the admitting privileges requirement futile. As explained above, abortion complications are rare. But when they arise, frequently they occur only after a patient has been discharged from a clinic and returned home. Indeed, complications following a medical abortion will never occur while the patient is still at the clinic because the medications used to induce the abortion take time to exert their effects. For example, if a medical abortion patient experiences heavy bleeding that requires hospital treatment, it will typically occur one to three weeks after the procedure.

31. If a woman who lives outside the area where she obtained abortion care experiences a complication that requires hospital treatment, it makes no sense for her to be treated at a hospital near the abortion clinic just because her abortion provider has admitting privileges there. She should go to the hospital emergency room that is closest to her home. In an emergency or potential emergency situation, no physician or EMT would countenance a patient traveling farther than necessary just to get to a hospital where her provider has privileges. For example, if a woman travels from McAllen to San Antonio for an abortion and experiences a complication when she returns home, the fact that the physician who performed the procedure has privileges at a San Antonio hospital would not make it medically appropriate for the woman to travel over 235 miles back to San Antonio rather than seeking care at a hospital near her home. Thus, insofar as it increases the distances that women must travel to obtain abortion services, the admitting privileges requirement is self-defeating.

32. In addition, the physician who provides the abortion may not be the appropriate physician to manage the patient's care in the hospital, regardless of whether the physician has privileges there. Given that abortions have such a low complication rate, abortion providers may, depending on their practice, only rarely perform the types of surgeries—including laparoscopy, open laparotomy, and hysterectomy—that might be necessary to treat a complication

requiring surgery, while the on-call ob/gyn at the hospital will have much more experience doing these procedures and will also be familiar with the systems in that hospital.

33. Moreover, the physician performing the abortion might not have the relevant expertise to treat the patient. For example, in the very rare case of uterine perforation with a vascular or bowel injury, it is critical that the patient be treated by the appropriate subspecialist *(i.e.*, a general or vascular surgeon). A woman with a cardiac or lung condition may need treatment from a cardiologist or pulmonologist. I rely on my colleagues to manage these complications and conditions, just as they rely on me to evaluate gynecologic pathology they might encounter during surgery they perform. Given how specialized the practice of medicine has become, particularly in hospital settings, such transfers to the appropriate specialists are common and necessary across medicine.

34. In addition, in those rare cases when an abortion patient, after discharge, goes to a hospital emergency room because of concerns or complications, she can often be treated in the emergency room without being admitted to the hospital. Emergency room physicians are qualified to evaluate and treat most complications of abortion. The skills needed to do so are the same as those needed for the treatment of miscarriages, which are often treated in hospital emergency rooms. If additional care is necessary, the on-call physicians at the hospital can provide it.

The ASC Requirement Departs from Accepted Medical Practice and Does Not Enhance the Safety of Abortion Care

35. My understanding is that the ASC requirement of H.B. 2 applies only to abortions performed prior to 16 weeks' gestation, and that a different provision of Texas law governs abortions beginning at 16 weeks. For that reason, I limit my opinions concerning the ASC requirement to abortions performed prior to 16 weeks.

36. Such abortions can be safely performed in office-based settings, such as doctors' offices and specialized clinics. For that reason, in Texas and nationwide, the vast majority of abortion procedures are performed in office-based settings. This is accepted medical practice. Indeed, ACOG's guidelines for the provision of abortion care do not require that abortions be performed in ASCs. In fact, they specifically condemn "[f]acility regulations that are more stringent [for abortion] than for other surgical procedures of similar risk."[6]

37 There are no data that demonstrate that requiring abortions to be performed in ASCs would enhance the safety of abortion care. And there is no

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[6] American College of Obstetricians and Gynecologists. Guidelines for Women's Health Care: A Resource Manual. 3rd ed. Washington, DC: American College of Obstetricians and Gynecologists; 2007 (P-192).

medical basis for requiring facilities in which abortions are performed to meet ASC standards.

38. Many of the minimum ASC standards imposed by Texas law—such as those related to maintenance of a one-way traffic pattern in the facility, segregation of the surgical suite, scrub facilities, detail and finish requirements, air flow and filtration, and humidity control—are geared toward creating and preserving a sterile operating environment. But, like other surgical procedures involving entry into the respiratory, alimentary, genital, or urinary tracts, which are naturally colonized by bacteria, surgical abortion does not entail an aseptic operating field.[7] The type of sterile precautions that are indicated for a procedure involving an incision into the body are therefore unnecessary when performing an abortion procedure and provide no benefit to the patient. A physician performing a Pap smear, for example, will typically wear a non-sterile glove to put fingers in the vagina for purposes of the examination because a sterile glove is not necessary, and will not need to sterilize the speculum before it is inserted into the vagina. For the same reason, a physician performing a surgical abortion need not wear sterile gloves as long as he or she avoids touching the

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[7] Meckstroth K, and Paul M, First-Trimester Aspiration Abortion. *Management of Unintended and Abnormal Pregnancy.* 2009; 144-45 (P-083); Rock, J and Jones, H. *TeLinde's Operative Gynecology.* 10th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2011:191,784 (P-037).

portions of the sterile instruments that will enter the patient's uterus.

39. Existing regulations governing licensed abortion facilities contain rigorous standards for quality assurance, infection control, and sterilization of instruments. These are diligently enforced by the Texas Department of State Health Services and more than adequate to ensure the health and safety of abortion patients.

40. The square footage requirement for operating rooms is also unnecessary for the safe provision of abortion care. Unlike more complex surgeries, abortion requires only a small number of medical personnel and a small amount of equipment. A procedure room much smaller than 240 square feet can accommodate all of the personnel and equipment needed to perform surgical abortion, including any personnel and equipment that may be needed in the rare event of a medical emergency. The excess space mandated by the ASC standards provides no health or safety benefit.

41. In addition, the ASC standards require levels of staffing that are excessive for surgical abortion care. For example, the standards require that ASCs have multiple registered nurses on staff. This is simply not needed for the provision of safe abortion care.

42. There is likewise no medical basis for requiring medical abortion to be provided in an ASC. Medical abortion does not entail any form of surgery;

it simply entails the ingestion of medication tablets. Further, as explained above, complications from medical abortion only arise after a patient has been discharged from an outpatient abortion facility; they never arise while the patient is still on-site.

Access to Legal Abortion is Vital to the Protection of Public Health

43. It is extraordinarily important for women to have meaningful access to legal abortion. Women of childbearing age who do not have access to the procedure face significantly increased risks of death and poor health outcomes. For example, when women are forced to travel long distances for care, many will delay obtaining an abortion until they can find the money or arrange transportation. While abortion is a safe procedure, the risks from abortion increase as the pregnancy advances. Thus, delaying abortion until later in pregnancy increases the risk of complications.[8]

44. Some women, deprived of access to legal abortion, forgo the abortions they would have obtained if they could and, instead, carry unwanted pregnancies to term. These women are exposed to increased risks of death and major complications

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[8] Bartlett LA, Berg CJ, Shulman HB, Zane SB, Green CA, Whitehead S, Atrash HK. Risk factors for legal induced abortion-related mortality in the United States. Obstet Gynecol. 2004 Apr;103(4):729-37 (P-098).

from childbirth, and they and their newborns are at risk of complications during pregnancy and after delivery.[9]

45. Furthermore, when legal abortion is unavailable or difficult to access, some women turn to illegal, and unsafe, methods to terminate unwanted pregnancies.[10] I trained as a medical student, intern, and resident before the Supreme Court's decision in *Roe v. Wade*. In those days, I saw many women who suffered and died as a result of illegal abortions. I hope never to see that again.

46. I am deeply concerned that the admitting privileges requirement and ASC requirement will have a negative impact on women's health by substantially reducing women's access to safe abortion care.

Dated: August 3, 2014
Austin, Texas

By: /s/ Paul M. Fine, M.D.
Paul M. Fine, M.D.

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[9] Gipson Jessica, et al., The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature, *Stud. Fam. Plan.* 2008; 39:18.

[10] Grossman D, Holt K, Pena M, Lara D, Veatch M, Cordova D, Gold M, Winikoff B, Blanchard K. Self-induction of abortion among women in the United States. Reproductive Health Matters 2010;18(36): 136-146 (P-160).

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH; *et al.*,	)	
Plaintiffs,	)	CIVIL ACTION
v.	)	CASE NO. 14-CV-284-LY
DAVID LAKEY, M.D.; *et al.*,	)	
Defendants.	)	

DIRECT TESTIMONY OF
SHERWOOD C. LYNN, JR., M.D.

(Filed Aug. 4, 2014)

SHERWOOD C. LYNN, JR., M.D., under penalty of perjury, testifies as follows:

1. I am a board-certified obstetrician-gynecologist and Senior Fellow of the American College of Obstetrics and Gynecology (ACOG). I have thirty-eight years of experience practicing medicine. Although I retired from most facets of my practice in 2006, I continue to provide abortion services because there is a critical need for these services and not enough physicians who are willing to offer them.

2. I graduated from the University of Texas Medical School at San Antonio 1976, and completed a residency in obstetrics and gynecology at Hermann Hospital and the University of Texas Medical School at Houston, where I served as the Chief Resident. I

later served on the faculty of the University of Texas Medical School at Houston for eight years, and then served as the Chief of Gynecology at the University of South Alabama College of Medicine, where I taught and practiced for over 13 years. Throughout the course of my career I have delivered thousands of babies and trained countless residents.

3. I currently serve as Medical Director of two Whole Woman's health facilities in San Antonio. One is a clinic and the other is an ambulatory surgery center ("ASC").

4. Over the course of my career I estimate I have delivered over 15,000 babies and done well over 15,000 gynecological procedures, including Cesarean sections and tubal ligations. I have participated in the training over 100 residents and many family practice physicians in obstetrics and gynecology.

5. I am familiar with the requirements of Texas House Bill No. 2 ("HB2"), including the "admitting privileges requirement," which mandates that all physicians who provide abortion services "have active admitting privileges at a hospital that . . . is located not further than 30 miles from the location at which the abortion is performed or induced," and the "ASC requirement," which mandates that "the minimum standards for an abortion facility must be equivalent to the minimum standards . . for ambulatory surgical centers" under Texas law.

6. I currently hold admitting privileges at hospitals in San Antonio and Austin.

7 After the passage of HB2, I worked with staff members at Whole Woman's Health to attempt to obtain admitting privileges at a hospital within 30 miles of the Whole Woman's Health clinic in McAllen, so that I could provide abortion services to the patients there once the admitting privileges requirement went into effect.

8. We determined that there are seven hospitals within 30 miles of the McAllen clinic that provide obstetric or gynecologic services: Rio Grande Regional Hospital, Mission Regional Medical Center, Doctors Hospital at Renaissance, and four hospitals within the South Texas Health System.

9. Whole Woman's Health staff members then contacted the hospitals to determine the procedures and requirements for obtaining admitted privileges.

10. All seven McAllen-area hospitals require, as a condition of granting admitting privileges, that an application be signed by a "designated alternate" physician willing to attend to the applicant's patients when the applicant is unavailable. The designated alternate physician must already have admitting privileges at the hospital. If an application is not signed by a designated alternate physician, it will not be considered, regardless of whether the applicant meets the hospital's other criteria.

11. Whole Woman's Health staff members reached out to numerous physicians in the McAllen area about serving as the required designated alternate physician for my applications to the McAllen-area hospitals. Only one physician was willing to do so, and that physician only held privileges at one hospital: Doctors Hospital at Renaissance. The other physicians that we contacted expressed concern about retaliation from the hospitals at which they had admitting privileges and the possibility that their privileges would be revoked or discontinued if they facilitated the application of a known abortion provider.

12. Thus, I was only able to satisfy the designated alternate physician requirement for one hospital within 30 miles of the McAllen clinic: Doctors Hospital at Renaissance.

13. The first step in applying for admitting privileges at Doctors Hospital at Renaissance is to send a letter requesting an application for admitting privileges. On September 23, 2013, I sent such a letter, a copy of which is being offered as Plaintiffs' trial exhibit P-069.

14. By letter dated November 4, 2013, the hospital notified me that my request for an application had been denied. The letter stated that the Medical Executive Committee had decided to deny my request for an application based on the recommendation of the hospital's Credentials Committee, but that this denial "was **not** based on clinical competence

consideration" (emphasis in original). The letter provided no other explanation for why I was being denied the opportunity to apply for admitting privileges at the hospital. Three colleagues of mine at Whole Woman's Health received identical letters from Doctors Hospital at Renaissance in response to their requests for admitting privileges applications. These letters are collectively being offered as Plaintiffs' trial exhibit P-068.

15. Despite having admitting privileges at hospitals in both San Antonio and Austin, I have been unable to obtain admitting privileges at a hospital within 30 miles of the McAllen clinic. In my view, the processes employed by these hospitals are arbitrary and discriminatory.

16. As the Medical Director of both the licensed abortion facility operated by Whole Woman's Health in San Antonio and the ASC operated by Whole Woman's Health in San Antonio, I am fully familiar with the incidence of complications that occur at each facility. I know for a fact that complications do not occur more frequently at the clinic than they do at the ASC, and that patients receive the same high quality of care in both facilities.

17. I am concerned about the closure of the McAllen clinic because of its impact on women in the Rio Grande Valley, who must now travel nearly 500 miles round trip to access legal abortion services. Even though I have retired from full ob-gyn practice, I continue to provide abortion care to women because

I believe the availability of safe, legal abortion services is essential for women's health and well-being.

Dated: August 3, 2014
Austin, Texas

By: /s/ Sherwood C. Lynn, Jr.
Sherwood C. Lynn, Jr., M.D.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH; *et al.*,	)	
Plaintiffs,	)	CIVIL ACTION
v.	)	CASE NO. 14-CV-284-LY
DAVID LAKEY, M.D.; *et al.*,	)	
Defendants.	)	

AMENDED TABLE 4 TO DIRECT TESTIMONY OF KRISTINE HOPKINS, Ph.D.

(Filed Aug. 4, 2014)

KRISTINE HOPKINS, Ph.D., under penalty of perjury, testify that set forth below is an amended Table 4 to my direct testimony:

Table 4, Revised with corrected numbers for "Total RGV Counties"

Table 4. Reported Pregnancies, Births, Fetal Deaths, and Abortions by County of Residence for Women Age 15-44, Texas and Selected Counties, 2011

State/County	Total Pregnancies*	Live Births	Fetal Deaths	Abortions	Percent of These Reported Pregnancies that Ended in Abortion
Texas	*447,652*	*376,185*	*2,036*	*69,431+*	*15.5%*
El Paso	16,140	13,866	92	2,182	13.5%
Lower Rio Grande Valley Counties					
Hidalgo	17,851	16,051	105	1,695	9.5%
Cameron	8,342	7,523	37	782	9.4%
Starr	1,466	1,356	5	105	7.2%
Willacy	334	297	0	37	11.1%
Total RGV Counties	*27,993*	*25,227*	*147*	*2,619*	*9.4%*

* Total pregnancies equals the sum of reported live births, abortions, and fetal deaths.

+ Includes abortions among Texas residents whose county of residence was unknown.

Source: Texas Department of State Health Services, https://www.dshs.state.tx.us/chs/vstat/vs11/t14a.shtm.

Dated: August 4, 2014
Austin, Texas

By: /s/ Kristine Hopkins
Kristine Hopkins, Ph.D.

Supreme Court, U.S.
FILED
DEC 2 8 2015
OFFICE OF THE CLERK

No. 15-274

In The Supreme Court of the United States

WHOLE WOMAN'S HEALTH ET AL. PETITIONERS

v.

KIRK COLE, M.D., COMMISSIONER OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

JOINT APPENDIX VOLUME III

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH, ABORTION ADVANTAGE, AUSTIN WOMAN'S HEALTH CENTER, KILLEEN WOMAN'S HEALTH CENTER, NOVA HEALTH SYSTEMS, SHERWOOD C. LYNN, JR. M.D., PAMELA J. RICHTER D.O., LENDOL L. DAVIS M.D.,	AU:14-CV-00284-LY
VS.	
DAVID LAKEY M.D., MARI ROBINSON.	AUSTIN, TEXAS AUGUST 4, 2014

* *

TRANSCRIPT OF BENCH TRIAL
BEFORE THE HONORABLE LEE YEAKEL

VOLUME 1 OF 5

* *

* * *

LENDOL L. DAVIS,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. TOTI:

[27] Q. Dr. Davis, have you submitted a written trial declaration in this proceeding?

A. Yes.

[28] Q. And does that trial declaration truthfully and accurately reflect your testimony in this case?

A. Yes.

MS. TOTI: Thank you very much.

THE COURT: All right.

MS. TOTI: Nothing further, Your Honor.

THE COURT: Cross-examination by the State?

MR. SOTO: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. SOTO:

Q. Good morning, Dr. Davis.

A. Good morning, sir.

Q. You are one of the plaintiffs in this case; is that correct?

A. Yes.

Q. And you're currently the medical director of Austin Woman's Health Center?

A. Yes.

Q. And you're also the medical director of the Killeen Woman's Health Center?

A. Yes.

Q. Both those clinics are plaintiffs in this case?

A. Yes.

Q. And both of those clinics either provide or provided abortion services?

[29] A. Yes.

Q. The Killeen clinic closed in June of this year?

A. Yes.

Q. That clinic at the time of its closure met the admitting privileges requirement?

A. Do what?

Q. That clinic, the Killeen clinic, at the time of its closure met the admitting privileges requirement in House Bill 2; is that correct?

A. Yes.

Q. If your clinic was willing to pay the licensing fee, that clinic would be open today; is that correct?

A. Yes.

Q. You and your wife recently purchased a 1-point—approximately $1.1 million building here in Austin in May; is that correct?

A. Would you repeat that. I'm a little bit hard of hearing.

Q. Sure. You and your wife recently purchased a $1.125 million building here in Austin in May; is that correct?

A. Yes.

Q. I'm going to ask you about intent of that purchase. It was purchased with the intent to convert it into an ASC that complies with House Bill 2; is that right?

A. Yes.

Q. And you intend for that ASC—when you purchased it, you [30] intended for that ASC to provide abortion services?

A. Yes.

MR. SOTO: No further questions, Your Honor.

THE COURT: Further direct?

MS. TOTI: Very briefly, Your Honor.

REDIRECT EXAMINATION

BY MS. TOTI:

Q. Dr. Davis, why did you close the Killeen facility?

A. We closed it because the licensing fee was due and, also, we were very, very, very reluctant to close it because we mainly serviced—since that is the location for Fort Hood, we serviced the military, both active duty and dependents.

And, as you know or many of you may know from the military, this is somewhat of a confidential problem when they have pregnancy and they may be getting ready to be deployed next week, they may be getting ready to go on maneuvers, they may not be willing to discuss this with their commanding officers. So the choice for them was to make many trips to Austin.

And we were very reluctant to close the clinic because of our commitment to the military, but we really didn't have much of a choice because of the upcoming law.

Q. And when you say "the upcoming law," what do you mean by that?

A. Well, we have admitting privileges in that area. But, on [31] the other hand, the—the ambulatory surgery center state law is so very, very, very expensive to convert or to redo a building and very time consuming, that it was not feasible to do that.

Q. In—and I believe you testified that you are investigating the feasibility of building an ASC in Austin; is that correct?

A. Yes.

Q. What is the status of those efforts?

A. We hired a specialist architect in ambulatory surgery centers and medical facilities and asked him to do a feasibility study. They came up with a proposal meeting all the State rigid requirements as far as an ambulatory surgery center. And our building is approximately 5,000 square feet and the feasibility study said that we needed approximately 7,000 square feet to meet the State standards.

Q. At this point do you plan to go forward with the project?

A. I'm sorry?

Q. At this point in time, do you have plans to go forward with the construction projection in Austin?

A. We are considering it. Once the completed feasibility study is finished, then we will look at it and see if it is a go or no-go. We have to look at financing. We have to look at how much we're going to be able to pass that expense on to the patients. And most of the patients we serve are indigent [32] patients, middle class, and some upper class. And our upper class patients can always go to another state. Middle class have some problems and it makes it very difficult for them. But indigent patients

unfortunately don't have much of a choice. And if you make it so high that they're unable to obtain an abortion, essentially, that choice is taken away from them.

Q. Do you have an understanding of, if you decide to go forward with the project, how long construction would take?

A. Construction, as everyone in here knows or most people knows, always takes longer. Our estimate is around 18 months for construction. That could go on for two years. As you know or many of the people in here know, construction in Austin has a number of difficulties in getting permitted and all the other things that go along with it.

Also we're at the mercy of the State on how long they take to approve the plans and all the other permitting and other things that may come up. We have an area that we may need additional parking, we may need to do impoundment of water, and a number of different things which may make it impossible to use this site. But it also, all these plans have to continue to go back and forth and back and forth through the City of Austin and maybe even the State.

MS. TOTI: Thank you, Dr. Davis. No further questions, Your Honor.

[33] MR. SOTO: No further questions.

THE COURT: You may step down.

THE WITNESS: Thank you.

MS. TOTI: Your Honor, the plaintiffs call Dr. Daniel Grossman.

THE COURT: All right.

(Witness sworn)

DANIEL A. GROSSMAN,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. TOTI:

Q. Dr. Grossman, have you provided a trial declaration in this matter?

A. Yes.

THE COURT: Pardon me. Whenever you call a witness, if you would start out by asking the witness to state his name so we make sure we have everything on the record.

MS. TOTI: Of course, Your Honor.

Q. (BY MS. TOTI) Dr. Grossman, could you state your full name for the record.

A. Daniel Grossman.

Q. Thank you. Have you submitted a trial declaration in this matter?

A. Yes, I have.

Q. Does that trial declaration represent a complete and [34] accurate statement of your direct testimony?

A. Yes, it does.

MS. TOTI: Your Honor, at this time the plaintiffs seek to move into evidence the trial declaration of Dr. Grossman. I believe that Plaintiffs' Exhibit 2, which was unopposed, has already been moved into evidence and Plaintiffs reserve the right to move into evidence the remaining exhibits that are cited in Dr. Grossman's declaration. Those are still subject to ongoing discussions with the defendants.

THE COURT: Any objection to the declaration of Dr. Grossman?

MR. STEPHENS: No, Your Honor. Although we would object to the plaintiffs' exhibits cited in that report as hearsay.

THE COURT: Well, that doesn't really help your record very much. You need to state an exhibit number or what exactly it is you're objecting to as hearsay.

MS. TOTI: Your Honor, I just want to clarify. We are not seeking to move the balance of the exhibits into evidence at this time. We just reserve the right to do it at the conclusion of the proceedings. We're hoping to have continuing discussions with the defendants about those exhibits and hopefully come to an agreement.

THE COURT: Well, yes. And you don't—you don't need to state that you're reserving your right for later. You [35] don't waive anything. We'll take that up later. So exactly then, Mr. Stephens, what is your objection?

MR. STEPHENS: Your Honor, we have no objection at this time.

THE COURT: All right. Then the declaration entitled Direct Testimony of Daniel Grossman, M.D., is admitted into evidence.

MS. TOTI: Thank you, Your Honor. No further questions for this witness.

THE COURT: All right. Cross-examination?

MR. STEPHENS: Andrew Stephens, Office of the Attorney General, for the State defendants.

CROSS-EXAMINATION

BY MR. STEPHENS:

Q. Good morning, Dr. Grossman.

A. Good morning.

Q. Dr. Grossman, you're one of the lead investigators for the Texas Policy Evaluation Project; is that correct?

A. That is correct.

Q. And that's referred to as Tex PEP; is that accurate?

A. That is correct.

Q. And the purpose of Tex PEP is to document and analyze the impact of measures affecting reproductive health passed by the 32nd and 83rd Texas legislatures; is that right?

A. Correct.

[36] Q. The data and analysis that you rely on for your opinions in your direct testimony was collected in part by Tex PEP; is that right?

A. That is not correct.

Q. Okay. Tex PEP played a role in researching and providing data that forms the basis of at least part of the opinions you're offering today; is that right?

A. That is incorrect.

Q. I'm sorry?

A. That is incorrect.

Q. Okay. Could you describe the role of Tex PEP?

A. Sure. Tex PEP is a collaboration among three organizations. It's led by Dr. Joseph Potter, who is the principal investigator based at University of Texas at Austin. The second institution is my own,

Ibis Reproductive Health. And the third is University of Alabama at Birmingham.

The data upon which my testimony is based is data that was collected by myself and colleagues at Ibis Reproductive Health. Colleagues who are part of Tex PEP based at University of Texas at Austin and University of Alabama at Birmingham were involved in some of the analysis, but they were not involved in the data collection.

Q. Okay. So it's your testimony that colleagues at Tex PEP were involved in the analysis that is in part provided as a basis for your expert opinions in this case; is that right?

[37] A. They participated in the analysis of the data that I collected with my colleagues at Ibis, yes.

Q. I understand. And who are the colleagues that you work with at Tex PEP?

A. As I mentioned, Dr. Potter is the principal investigator; Dr. Christine Hopkins, who is also at University of Texas at Austin; Dr. Carey White, who is at the University of Alabama at Birmingham; and myself. We are the four lead investigators.

Q. And you're aware that Dr. Potter submitted a declaration and a rebuttal declaration in the case tried in this Court last fall challenging the admitting privileges requirement of House Bill 2; is that right?

A. I am.

Q. And you're aware that Dr. Potter gave expert testimony in that case tried in this court last fall challenging the admitting privileges requirement; is that right?

A. Yes.

Q. And you're familiar with the declarations that were submitted by Dr. Potter in that case?

A. Yes. I'm familiar with the general—the general outline of what he submitted, yes.

Q. And those declarations that were submitted in that case were also based in part on Tex PEP analysis; is that right?

A. Based on different data, but yes. They were based on different data and analysis done by Tex PEP on different data.

[38] Q. Right. Tex PEP participated in the analysis that formed the basis and part of those declarations that Dr. Potter submitted, right?

A. Yes.

Q. In fact, you co-authored the declarations that Dr. Potter submitted in that case; is that right?

A. I was part of the analysis team that was part of that, yes.

Q. And Dr. Potter testified in this court that Dr. Grossman and myself, referring to Dr. Potter,

principally authored all of the writing of those declarations; is that correct?

A. Yes.

Q. Tex PEP, in the declarations that were submitted by Dr. Potter in the last case, told this court that, following the admitting privileges requirement going into effect, three of the six ASCs located in the State of Texas providing abortion services would close. Do you recall that?

A. I don't recall the precise number, but I—but I do remember that there was—that some of the ASCs were projected to close.

Q. Okay.

MR. STEPHENS: Your Honor, may I approach?

THE COURT: You may. And let me say this to all the lawyers. In my Court you don't have to ask to approach the witness. If you have something you need to take to the witness [39] or discuss with the witness, go to the witness, be there as short a period as possible and return to the podium. It just takes up too much time to ask for leave. If I think you're badgering the witness, I won't hesitate to say something to you about it.

MR. STEPHENS: Thank you, Your Honor.

Q. (BY MR. STEPHENS) Dr. Grossman, is this the declaration Dr. Potter submitted in the case that

was tried in this court last fall that you co-authored with Dr. Potter?

A. Yes.

Q. And turning to paragraph 7, which is on page 3 of this declaration, could you review that paragraph, please?

A. (Witness reviews document)

Q. Have you had a chance to review that paragraph?

A. Yes.

Q. Dr. Grossman, do you see the sentence in that paragraph that says, "Only six abortion clinics in Texas are licensed as ASCs. Of those six, three will stop providing abortion care as a direct result of the admitting privileges law, leaving only three providing abortions—one in Dallas, one in Houston, and one in San Antonio." Do you see that sentence?

A. Yes.

Q. And how many abortion provider ASCs are currently providing abortions in the State of Texas?

A. That are currently providing? To the best of my [40] knowledge, there are—that are currently providing, to the best of my knowledge, are five.

Q. Okay. So three abortion ASCs did not close after the admitting privileges requirement went into effect; isn't that right.

A. They did close for some period of time, but they did not remain closed.

Q. Are you aware of any additional ASCs that are opening to provide abortion services in the State of Texas?

A. I am aware that—I know there has been an ASC announced by Planned Parenthood of Greater Texas in Dallas that is scheduled to open.

Q. And that's scheduled to open in August of this year; is that right?

A. I don't know the exact timing. My understanding is that it is planned to be operational by September 1st.

Q. And are you aware of whether Planned Parenthood has plans to open an additional ASC to provide abortion services in San Antonio?

A. I am aware of the plans for that. My—after my discussions with staff in that affiliate, my understanding is it will not be operational by September 1st.

Q. Okay. But you have heard that there are plans that Planned Parenthood has plans to open an ASC in San Antonio; is that right?

[41] A. Correct.

Q. At the end of paragraph 7 of the declaration that you co-authored with Dr. Potter, it states, "We calculate that the shortfall in capacity due to the

admitting privileges requirement will prevent at least 22,286 women from obtaining a safe and legal abortion in the next year. In other words, nearly one in three women." Do you see that sentence?

A. Yes, I do.

Q. In your direct testimony in this case, you've estimated the decline in the number of abortions to be approximately 9,200; is that correct?

A. That is what we measured, yes.

Q. Okay. So that's significantly lower, approximately 13,000 lower, than what had been previously estimated by Tex PEP prior to the admitting privileges requirement going into effect; is that right?

A. That is correct.

Q. Do you have a copy of your direct testimony?

A. I do not.

Q. Okay. And if you could take a moment to look through that direct testimony.

A. (Witness reviews document)

Q. Is that the testimony that you've sworn to on direct today?

A. Yes.

[42] Q. In paragraph 17 you testify that, "After the admitting privileges requirement went into effect, about 50 percent of the women in the Rio Grande

Valley who received abortions received those abortions at the clinic in Corpus Christi." Is that right?

A. That is correct.

Q. How many women from the Rio Grande Valley receiving abortions received those at the Corpus clinic following the admitting privilege requirement?

A. I'm sorry. I didn't quite understand. Can you say that again?

Q. Sure. Do you know how many women from the Rio Grande Valley traveled to Corpus for abortion services after the admitting privilege requirement went into effect?

A. So during the six month—during the period three, it was—I don't have the exact numbers from our estimate from our data in front of me. But as you can see in the table, so it was probably 500 women.

Q. Okay. And you said—and you said that was an estimate; is that right?

A. Correct.

Q. And, in fact, at your deposition you testified that Tex PEP, or you, did not obtain data from the clinic in Corpus Christi; is that right?

A. That was one of five clinics that we did not obtain data [43] from.

Q. Okay.

A. And we relied on knowledgeable experts for—knowledgeable sources to provide data about the number of women who were seen there.

Q. And who were those knowledgeable sources or experts, as you referred to?

A. So the IRB approval for our study prevents me—I mean, I have to maintain confidentiality of individuals. But I can say, in general, these were people who were in the nearby communities who had other providers who were aware of the volume, who had also talked to former employees who were working in that clinic. Those are the kinds of people that we talked to in terms of the knowledgeable sources.

Q. Okay. And starting with the other providers in the community, there wasn't another provider in that community—

A. Larger communities. So in Houston.

THE COURT: Dr. Grossman, let him finish his question before you answer. The court reporter can't get you both when you're talking over one another.

THE WITNESS: I apologize.

Q. (BY MR. STEPHENS) There was not another provider in the community to speak with about the numbers that you estimated for the Corpus Christi clinic, right?

A. There is no other provider in Corpus.

[44] Q. So that was from somebody in Houston?

A. Correct.

Q. You also testified in paragraph 17 of your direct that, "After the admitting privileges requirement went into effect, about 15 percent of the women in the Rio Grande Valley who received abortions received those abortions in San Antonio." Do you see that?

A. Correct.

Q. And do you know how many women received those abortions in San Antonio? The number?

A. Again, I don't have my—the actual data in front of me, but it's approximately 15 percent of the 1,065.

Q. Okay. And you also testified at your deposition that you did not obtain data from at least one clinic in San Antonio; is that right?

A. That clinic closed in June 2013.

Q. Okay. So no estimates were applied for the number of women that make up the 15 percent of your estimate; is that right?

A. I don't believe—we got data from all the clinics that were open in San Antonio for period three.

Q. So your testimony at your deposition, that there was one clinic in San Antonio for which you were unable to obtain data, that was a misstatement?

A. No. That was an accurate statement. That was talking [45] about the entire course of the study which began in November of 2012. But that clinic closed in what we refer to—what I refer to in my testimony as period two, which was June 2013.

Q. Do you know how many miles it is to drive from the Rio Grande Valley to San Antonio?

A. About 250, I believe.

Q. Around—between 238 and 250? Somewhere in there? Does that sound right?

A. My understanding, it was about 250.

Q. So those 15 percent—the 15 percent of the women from the Rio Grande Valley who received abortions in San Antonio of course traveled that distance to San Antonio; is that right?

A. That is correct.

Q. You also testified on direct that after the admitting privileges requirement went into effect, about 25 percent of the women in the Rio Grande Valley who received abortions received those abortions in Houston. Do you see that at paragraph 17?

A. (Nods).

Q. Do you know approximately how many miles it is from the Rio Grande Valley to Houston?

A. I believe it's a little over 300, but I'm not entirely sure.

Q. So at least 25 percent of the women traveled over the 300 miles from the Rio Grande Valley to Houston to obtain abortion [46] services; is that right?

A. That is correct.

Q. And then there was another 10 percent of women in the Rio Grande Valley who received abortions at a facility in a location other than Corpus Christi, Houston, or San Antonio; is that right?

A. That is correct.

Q. And so that 10 percent traveled to a clinic located further than Corpus, San Antonio, or Houston; is that right?

A. That is correct.

Q. Did you interview any women from the Rio Grande Valley who told you that she was unable to travel to San Antonio or Houston to obtain an abortion?

A. I'm not basing my testimony today on any interviews that I did.

Q. Is the answer no?

A. I'm not basing—no. I'm not basing my testimony on that. No.

MR. STEPHENS: Your Honor, could you instruct the witness to answer the question?

THE COURT: Why don't you ask the question again. Listen to his question, and answer the question he asks you.

Q. (BY MR. STEPHENS) Did you interview any woman from the Rio Grande Valley who told you that she was unable to travel to San Antonio or Houston to obtain an abortion?

[47] A. Yes, I did.

Q. And how many women did you interview who told you that they were unable to travel to San Antonio or Houston to obtain an abortion?

A. We interviewed 20 women who were turned away from various clinics that closed, including women from the Rio Grande Valley. Of those 20 there were—again, I don't have all the data in front of me, obviously. But there were two women who did not obtain the abortion that they wanted to obtain.

Q. Two women from the Rio Grande Valley?

A. No. You asked me how many I had spoken to who hadn't—if we're talking specifically about the Rio Grande Valley, I believe there was one of those women that we spoke to did not. So one. And I don't remember the exact number of women from the Rio Grande Valley that we interviewed.

Q. So your testimony is that two out of 20 that—who were interviewed told you that they were unable to travel the distance to a clinic?

A. Correct.

Q. And one of those two was in the Rio Grande Valley?

A. I believe that is the case, yes.

Q. And the other 18 you interviewed made no indication that they would be able to travel the distance to an abortion clinic for abortion services?

A. Many of them had delays of sometimes several weeks before [48] they were able to obtain enough funding or get time off work to be able to travel. But the other women—the other 18 women did obtain the abortion eventually that they wanted.

Q. I'm turning now to your testimony regarding complications from abortions performed at ASCs and non-ASCs. Do you see that section of your direct testimony?

THE COURT: Why don't you refer us to the paragraph number.

Q. (BY MR. STEPHENS) It's beginning on paragraph 43 of your direct. Do you see that section?

A. Yes.

Q. And this was an analysis of complications based on data you had received or Tex PEP had received from Plaintiff Whole Woman's Health; is that right?

A. Data that we at Ibis Reproductive Health obtained from Whole Woman's Health, yes.

Q. And you reviewed complication logs for Whole Woman's Health; is that right?

A. Yes.

Q. The accuracy of those complication logs is assumed as part of your analysis; is that right?

A. I don't completely understand what you're saying.

Q. Your analysis of complication rates at the Whole Woman's Health ASC versus the Whole Woman's Health non-ASC abortion clinics is based on the analysis of complication logs from [49] those facilities; is that right?

A. That is correct.

Q. So your opinions regarding the complication rates at those facilities rests on the assumption that the logs you reviewed were accurate; is that right?

A. The logs and, as I have also testified in my deposition, my discussions with staff at Whole Woman's Health, yes.

Q. So it was a combination of the logs and discussions with Ms. Ferrigno at Whole Woman's Health; is that right?

A. That is correct.

Q. And all of that information was provided either through the Whole Woman's Health logs or Ms. Ferrigno; is that right?

A. Correct.

Q. You submitted an expert report in this case; is that right?

A. Yes.

Q. And in your expert report you stated that, based on your review of the complication logs, you had identified three complications—I'm sorry—two complications at the Whole Woman's Health non-ASC facilities; is that right?

A. I believe that in my original declaration there were three initially.

Q. And now your testimony today is that there were in fact five at the non-ASC facility for Whole Woman's Health; is that right?

[50] A. That is correct.

Q. That's changed because, after you submitted your report, you found that there were actually two more major complications that had occurred at the non-ASC Whole Woman's Health facility; is that right?

A. As I mentioned—as I discussed in the deposition, that was entirely my fault. It was—it was data that—those cases were in the complication logs. They had been abstracted into an Excel file, and we were still waiting on some additional information and they hadn't been included in the initial report that I submitted. But when we did obtain that additional information, I did include them.

Q. Okay.

A. They were in—excuse me for interrupting—they were included in the logs.

Q. They were not included in the first version of the report that you submitted; is that right?

A. That's correct.

Q. So you overlooked those. Not that they weren't included in the log?

A. That is correct.

Q. Do you currently provide abortion services at Planned Parenthood facilities in California?

A. I provide services at Planned Parenthood Shasta Pacific, yes.

[51] Q. And you perform abortions at Planned Parenthood Shasta Pacific; is that right?

A. Yes.

Q. How many—approximately how many abortions have you performed in your career?

A. Approximately 5,000.

Q. You previously worked at the Population Council; is that right?

A. That is correct.

Q. Does the Population Council provide any funding of Tex PEP?

A. No.

Q. No? You note—I'm going to refer to paragraph 7 of your direct testimony. I'm sorry. Paragraph 9. Do you see that paragraph?

A. Yes.

Q. And that paragraph states, "Our findings were recently accepted for publication in a peer-reviewed journal, Contraception." Is that right?

A. Yes.

Q. And when you say "our findings," are you referring to Tex PEP?

A. Yes. The Tex PEP researchers are all coauthors on that paper.

Q. Okay. And that paper is referred to here because the [52] findings in that paper reflect the findings that are set forth in your direct testimony; is that right?

A. Some of them; not all of them. But yes.

Q. Okay. And which ones?

A. The findings about the change in the abortion rate after HB 2 went into effect and the findings about the change in the number of reproductive-age women in Texas living at various distances from a facility providing abortion services in Texas.

Q. Dr. Grossman, is this a copy of the version that has been accepted for publication in the Journal of Contraception?

A. Yes, it is.

Q. I'd like to refer to paragraph—sorry—page 9, the second full paragraph. Do you see in that paragraph towards the bottom where it says, "Our findings suggest that most women desiring an abortion, but not all, overcame the barriers of distance and additional cost to obtain the service they needed"?

A. I'm sorry. I was on the wrong page. Which page again are you talking about?

Q. Page 9.

A. And which paragraph?

Q. The second full paragraph.

A. Yes.

Q. Do you see that language?

A. Yes.

[53] Q. And you are coauthor of this accepted version of the Tex PEP research?

A. Yes.

Q. And that's referring to the findings of the research regarding the effects of the admitting privileges requirement; is that right?

A. It's all—there were three provisions of HB 2 that had gone into effect in the period that we were looking at. And I realize they're not all relevant to this case here, but we're looking at the impact of essentially all three of those privileges—all three of those provisions.

Q. And this was conducted after the admitting privileges requirement went into effect; is that right?

A. Yes.

Q. So this analysis was observing the effect of the admitting privileges requirement; is that right?

A. Well, I also believe that some of the effect that we're seeing is related to the restrictions on medical abortion as well. I don't believe that's relevant to this case.

Q. And this is an accurate statement in this manuscript that states, "Our findings suggest that most women desiring an abortion, but not all, overcame the barriers of distance and additional cost to obtain the service they needed"?

A. For the period that we were looking at, yes, that's correct.

[54] Q. Okay. On page 11 of the accepted for publication version of your analysis, I'd like you to look at the first full paragraph. In here you state, "This analysis has several limitations. Since this is an observational study, we cannot prove causality

between the State restrictions and falling abortion rate." Is that right.

A. That's correct. And the sentence continues.

MR. STEPHENS: No further questions, Your Honor.

THE COURT: Redirect?

REDIRECT EXAMINATION

BY MS. TOTI:

Q. Hello, Dr. Grossman.

A. Hello.

Q. Mr. Stephens asked you questions about data that was submitted in a prior case concerning the admitting privileges requirement. Do you recall those questions?

A. Yes, I do.

Q. Are you relying on that data as a basis for your opinions in this case?

A. I am not.

Q. Is there any relationship between the data—the data collected in that case and the data that you collected related to this case?

A. There is no relationship.

Q. Are there any similarities between the two data sets?

[55] A. There are no similarities between the two data sets.

Q. I believe that Mr. Stephens asked you some questions about the six licensed ambulatory surgery centers in Texas that provide abortion services. Do you recall those questions?

A. Yes.

Q. To the best of your knowledge, are all of those facilities currently scheduling patients for abortion services?

A. To the best of my knowledge, they are not all currently scheduling patients.

Q. And do you have an understanding about why some of those facilities aren't scheduling patients for abortion services?

A. My understanding is that it's related to hospital privileges of the—of the provider, of the physician.

Q. So some of the facilities are having difficulties satisfying the admitting privileges requirement. Is that your understanding?

A. That is my understanding.

Q. Okay. I believe Mr. Stephens also asked you some questions about the percentages of women who were able to travel outside the Rio Grande Valley to obtain abortion services during your study period. Do you recall those questions?

A. Yes.

Q. And some women were able to travel outside the Rio Grande Valley to obtain abortion services; is that correct?

[56] A. That is correct.

Q. Do you have an opinion about whether all women from the Rio Grande Valley can travel outside the region to obtain abortion care?

A. I believe that not all women can travel, especially with the additional distance that's required to travel to San Antonio. Part of the issue is that we don't know what the actual true demand for abortion is if we're talking specifically about the Rio Grande Valley. This was an area that was hard hit by cuts in public family planning services, and I believe there is reason to believe that there is increasing unintended pregnancy in that area. But I do not believe that all those women are able to travel to obtain the abortion services that they want or need.

Q. And what is your opinion in this regard based on?

A. I mean, it's based on my understanding of—of this area, that it's an area that has high levels of poverty, from my discussions with providers there, and also, as I mentioned to Mr. Stephens, our interviews with women there as well.

THE COURT: At this time we'll take our morning recess and we'll be in recess for 15 minutes.

Again, the Court appreciates the lack of comfort we have in our seating area. When you come back in, if you will close up as close as you can so as many people who can, can be seated, I would appreciate it.

[57] We'll be in I recess until 10:45.

(Recess)

(Open Court)

THE COURT: Ms. Toti, you may continue your redirect examination.

MS. TOTI: Thank you, Your Honor.

Q. (BY MS. TOTI) Dr. Grossman, I'm just going to ask you to take one more look at the *Contraception* article that Mr. Stephens had asked you about.

If you'll direct your attention to page 11, the first full paragraph, I believe that Mr. Stephens had asked you to read part of that paragraph into the record; is that right?

A. Or he read it, yes.

Q. Can you—can you please read the second, third, and fourth sentences in that first full paragraph on page 11.

A. Starting with "since"?

Q. I don't have it in front of me. But if you go to the first full paragraph on page 11, beginning with the second sentence, which I believe is the one that Mr. Stephens started to read to you.

A. "Since this is an observational study, we cannot prove causality between the State restrictions and falling abortion rate. The timing, however, is suggestive of a link."

Would you like me to continue?

Q. Yes, please. The next two sentences.

[58] A. "In addition, where data were not directly available, we used informants or made internal estimates. However, our estimates for period one are similar to the numbers reported by the State for 2012."

Q. Thank you, Dr. Grossman.

MS. TOTI: I have no further questions, Your Honor.

THE COURT: Recross, Mr. Stephens?

RECROSS-EXAMINATION

BY MR. STEPHENS:

Q. Dr. Grossman, your opinion in part is that, as a result of the ASC requirement, certain non-ASC abortion clinics in the State of Texas will close; is that right?

A. That is correct.

Q. So the doctors who perform abortions at those non-ASC clinics that will close will be available to provide abortion services at the ASCs that remain open; is that right?

A. Possibly. I don't know.

MR. STEPHENS: No further questions, Your Honor.

THE COURT: Anything further, Ms. Toti?

MS. TOTI: No, Your Honor.

THE COURT: You may step down.

MS. TOTI: Your Honor, at this time the plaintiffs call Dr. Paul Fine.

(Witness sworn)

* * *

[59] PAUL M. FINE,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. TOTI:

Q. Good morning, Dr. Fine. Could you please state your full name for the record.

A. Good morning. Paul Fine.

Q. Thank you. Dr. Fine, have you submitted a trial declaration in this case?

A. I have.

Q. And does that declaration contain a complete and accurate statement of your direct testimony?

A. Yes, it does.

MS. TOTI: Thank you. Your Honor, I move the declaration of Dr. Fine into evidence.

THE COURT: Any objection?

MR. STEPHENS: No objection, Your Honor.

THE COURT: All right. The declaration entitled Direct Testimony of Paul M. Fine, M.D. is admitted.

MS. TOTI: No further questions, Your Honor.

THE COURT: Cross-examination?

MR. STEPHENS: Andrew Stephens, Office of the Attorney General.

* * *

[60] CROSS-EXAMINATION

BY MR. STEPHENS:

Q. Good morning, Dr. Fine.

A. Good morning, Mr. Stephens.

Q. Dr. Fine, part of your opinion is that the complication rates for abortions performed in

non-ASCs versus abortions performed in ASCs are no different; is that right?

A. My opinion is that the physical requirements of an ASC do not enhance the safety of an already extremely safe procedure, abortion.

Q. Okay. So it's your opinion that it's already an extremely safe procedure; is that right?

A. You're talking fast, and I can't hear you.

Q. I'm sorry. I'll slow down.

Is it your opinion that abortion is already an extremely safe procedure, as you said?

A. Yes, it is. One of the safest in medicine.

Q. Okay. And what's the basis of that opinion?

A. Published complication rates of abortion.

Q. Okay. So that opinion rests, at least in part, on complication rates?

A. Published complication rates, correct.

Q. And how are those complication rates derived?

A. The complication rates are derived from multiple sources, including not only federal and state records, but also the [61] majority of abortion clinics are either Planned Parenthood clinics or members of the National Abortion Federation, who require all members to submit complication data to them on a

regular basis for medication abortion to Danco Labs, who manufacture the pill, are required by the FDA, who are also required to submit complication data regarding medication abortions to Danco Labs. Additionally, the published data includes sources from Medicaid, where Medicaid pays for abortion. So multiple sources are used in addition to state and federal data.

Q. Okay. So, ultimately, it's derived from records provided to one of those organizations by an abortion clinic; is that right?

A. That's one of the sources that I just described, yes.

Q. Okay. And where would the—what other source what would be the other source of the records that you described?

A. As I just mentioned, from Medicaid data, from hospital discharges, from hospital records, from—from various sources—media.

Q. Okay. And as to the records that are submitted by the clinic themselves, your opinion regarding the safety of abortion procedures rests on the accuracy of the reporting by those clinics; is that right?

A. Yes.

Q. And so your opinion rests on the assumption that the data [62] provided by those clinics is true and accurate; is that right?

A. Correct.

Q. Dr. Fine, do you know whether the records are true and accurate that are submitted by those clinics?

A. I believe they are.

Q. Okay. And what's the basis of that belief?

A. The clinics generally are aware when complications occur.

Q. All clinics?

A. The majority of clinics that are members of the National Abortion Federation or Planned Parenthood clinics, and those two entities comprise the vast majority of abortion clinics in this country.

Q. Dr. Fine, are you currently an abortion provider?

A. Yes, I am.

Q. And where do you provide abortions?

A. At Planned Parenthood Center for Choice which is, for purposes of this hearing, Planned Parenthood Gulf Coast in Houston.

Q. That's in Houston, Texas?

A. Yes.

Q. That's an ASC?

A. It currently is.

MR. STEPHENS: No further questions, Your Honor.

THE COURT: Any redirect?

MS. TOTI: Very briefly, Your Honor.

[63] REDIRECT EXAMINATION

BY MS. TOTI:

Q. Good morning, Dr. Fine.

A. Good morning.

Q. Does your opinion about abortion complication rates rest solely on data that's reported by abortion clinics?

A. No, it's not. In addition, we've become aware of these complications—well, once the clinic becomes aware of complications, then they must—they report them. And clinics become aware of complications by several methods. We often receive calls after hours and we refer patients to an emergency room if they're having heavy bleeding or cramping. So we're aware of it from that, and we follow up with the patient.

Other times the patient may go to the emergency room without contacting the on-call physician, and the emergency room physician may contact us. And so I've talked to a number of emergency rooms. So that's another way we find out the patient has had a complication requiring her to go to the emergency room.

And then the third way for sure is that many patients, after they've gone to an emergency room or have been treated in a hospital call the clinic quite upset, that they want financial compensation for the money they spent going to an emergency room or being admitted to the hospital.

So from multiple sources we find out about [64] complications, and I believe the clinics are accurate in reporting them as required by either Planned Parenthood or NAF.

In addition to my over 40 years of experience in providing abortion care, I've also been a medical director for 30-plus years. I've reviewed complication logs. I'm aware of the complications that occur. And the publications citing the extremely low complication rate are on target. Abortion is one of the safest procedures in medicine. For mortality wise, it's safer than a shot of penicillin.

MS. TOTI: Thank you, Dr. Fine. No further questions, Your Honor.

THE COURT: Mr. Stephens?

MR. STEPHENS: No further questions, Your Honor.

THE COURT: All right. You may step down.

MR. LAWRENCE: Your Honor, good morning. The plaintiffs call Mr. George Johannes.

(Witness sworn)

GEORGE JOHANNES,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. LAWRENCE:

Q. Good morning, Mr. Johannes?

A. Good morning.

Q. Did you submit a trial declaration in this case?

A. I did.

[65] Q. And does it contain a complete and accurate statement of your direct testimony?

THE COURT: Mr. Lawrence, please remember my earlier request that the first question be to have the witness state his name so the record is clear who is on the stand.

MR. LAWRENCE: I do apologize, Your Honor.

Q. (BY MR. LAWRENCE) Mr. Johannes, could you please state you name for the record.

A. George Johannes.

Q. Thank you, Mr. Johannes.

MR. LAWRENCE: Apologies, Your Honor.

Q. (BY MR. LAWRENCE) Let me ask the question again just to make sure I got it clear. Does

the trial declaration that you submitted in this case contain a complete and accurate statement of your direct testimony?

A. Yes, it does.

MR. LAWRENCE: Your Honor, the plaintiffs move into evidence the direct testimony of Mr. Johannes.

THE COURT: Any objection?

MS. KANE: No objection, Your Honor.

THE COURT: All right. The declaration entitled Direct Testimony of George W. Johannes, AIA, is admitted.

MR. LAWRENCE: And, Your Honor, for now we'll pass the witness to the defendants.

THE COURT: All right. Thank you.

[66] CROSS-EXAMINATION

BY MS. KANE:

Q. Good morning, Mr. Johannes. My name is Erika Kane. I'm with the Office of the Attorney General, here on behalf of the State.

A. Good morning.

Q. Now, you're an architect licensed in Missouri, correct?

A. That's correct.

Q. And you've never been licensed as an architect in Texas, correct?

A. That's correct.

Q. And you've never designed a building to be constructed in Texas; is that correct?

A. That's correct also.

Q. And you also have no medical background or education; is that correct?

A. That's correct.

Q. And you've never observed an abortion service yourself, correct?

A. That's correct.

Q. But your wife is the director of an abortion clinic in Missouri; is that correct?

A. In Illinois.

Q. In Illinois. I'm sorry. And you know one of the plaintiffs in this case, Amy Hagstrom Miller, through attending [67] National Abortion Federation meetings with your wife; is that correct?

A. That's correct.

Q. Now, one of the opinions you offer in this case is that it's unusual for the government not to permit older buildings to be grandfathered when building codes and things of that nature change; is that correct?

A. Yes.

Q. And your opinion regarding grandfathering is based on assumption that requiring older buildings to comply with new requirements often imposes costs to come into compliance, correct?

A. That's correct. It doesn't just apply to older buildings, though.

Q. I'm sorry?

A. I said the principle doesn't apply just to older buildings, though.

Q. Okay. Buildings that already exist when the code changes, because costs might be associated with coming into compliance with the new code, oftentimes, grandfathering would be allowed of those existing buildings. Would that be an accurate reflection of your statements in your opinion?

A. Yeah. It creates a total lack of predictability from a business facility standpoint if every three years buildings would have to be changed.

[68] Q. Thank you. And when you offer your opinion regarding whether it's reasonable to grandfather the facilities at issue in this case such that they would have to comply with the ASC requirements that are at issue in this case, your opinion is not taking into consideration medical benefits that the ASC requirements might allow for; is that correct?

A. Well, the specifics of procedure safety is beyond—that's something for a medical professional.

But in my work with about 25 clinics that are not ASCs, there seems to be no benefit, and my direction typically is to match the facilities with the level of care that's provided by the facility.

Q. But because you have no medical training, you don't have a basis upon which to offer an opinion regarding the medical benefits of the ASC requirements?

A. No. I have no way of verifying that they're telling me the truth. But that's always the case with my clients.

Q. Now, you offer an opinion that the fact that the ASC requirements do not allow exceptions for older buildings is a departure from prevailing standards; is that correct?

A. That's correct.

Q. Now, in making that statement, you didn't survey Texas building codes to determine when grandfathering is generally allowed or not allowed, did you?

A. Not across the board. It's allowed in ASC—your current ASC regulations, except for abortion clinics.

[69] Q. In other states?

A. In Texas.

Q. In Texas. Okay. But you didn't survey generally business codes across the board outside the ASC context?

A. As to whether—

Q. Grandfathering is generally allowed?

A. —grandfathering is prohibited in Texas?

Q. Yes.

A. No, I didn't. I would be surprised to find that out.

Q. Now, in coming to your opinion that not allowing grandfathering is a radical departure, as you say in paragraph 17 of your testimony, did you rely on any outside studies or research to come to that opinion?

A. That it's unusual—

Q. Yes.

A. —for that not to be available?

Forty years of practicing architecture and dealing with building departments and—

Q. So other than your personal experience—

THE COURT: Wait.

MS. KANE: I'm sorry, Your Honor.

THE COURT: Same thing I told Dr. Grossman, but this time the other way. Don't interrupt him

until he finishes his answer so the court reporter can get everything down.

MS. KANE: I apologize, Your Honor.

[70] THE COURT: You may finish.

A. Yeah. I've worked in many cities, many states, and I—there's only two occasions where I've ever run into a denial of grandfathering.

Q. So you're relying solely on your experience in this case?

A. Yes. Which is unfortunately a lot.

Q. Now, in forming your opinions, you cite to a number of modeled building codes; is that correct?

A. That's correct.

Q. And let me ask you one question: In your testimony you used the term "grandfathering," but then there's also a term that I believe you used called "waivers"?

A. Yes.

Q. And there's a difference between the two, correct?

A. That's correct.

Q. And, in your experience, are you aware of any—

And grandfathering—and correct me if I'm wrong—is a situation in which a new or an—a

building that exists does not have to comply with a new requirement. Would that be accurate?

A. You're saying is that grandfathering?

Q. Yes.

A. Yes.

Q. Okay. And in its entirety, correct?

A. Of the specific change, yes.

[71] Q. So in this case, when you speak of grandfathering with respect to the ASC requirement, you're talking about a situation in which the existing facility would not have to comply with the ASC requirement at all? Or are you talking about something different?

A. No. Typically it would—the new law would not apply to the existing operating facility.

Q. In any—in any degree whatsoever?

A. I can't think of a situation so extreme that you would have to require that change.

Q. Okay. And are you aware—I believe you've—you're aware of an ASC requirement in Michigan, correct?

A. Right.

Q. And in that case did they—did the State allow for grandfathering of existing facilities in their entirety?

A. What they did there—I think I have said previously that they didn't allow or they did allow—I'm sorry.

They did not allow grandfathering in. But the health department there, not actually looking to shut clinics down, per se, agreed to work out waivers with a lot of the clinics.

Q. Okay. Now, in rendering your opinions, did you review an local building codes such as in El Paso and McAllen?

A. No. They weren't really—

Q. And to the extent—

A. —pertaining to this.

[72] Q. I'm sorry. And to the extent your report references model codes such as the International Building Code or IBC, you don't know if El Paso or McAllen have adopted that model code, correct?

A. No. And it wouldn't pertain to this Texas state law in any event.

Q. And you're not—to the extent your report references something called the FGI guidelines, you don't know if Texas or, more specifically, El Paso and McAllen, have adopted the FGI guidelines?

A. To my knowledge they have not.

Q. Okay. And would you agree that model building codes like the FGI guidelines just set a floor of minimum standards for buildings?

A. The way the process—the building process works, they end up being usually the minimum standard and typically the maximum as well, as is often the case with regulation.

Q. But it would not be unusual for a local government to enact building codes that might be stricter than the model codes that you rely on in your testimony?

A. No. That happens in some very special cases. Where the situation in that state or city is different than others, they may very well add some. Earthquakes in California, for example, is more severely looked at than in other states.

Q. Now, your opinions regarding whether the ASC requirement [73] is reasonable turns in part on your assumption—

A. I'm sorry. Which requirement?

Q. Your opinions regarding the ASC requirement—

A. Okay. Okay.

Q. —is reasonable. You provide that opinion, whether the ASC requirement is reasonable, turns in part on an assumption that an aseptic surgical field is not needed to perform an abortion; is that correct?

A. Yes.

Q. Okay. Be you're not a medical professional, correct?

A. No. This is information I've been told by clinicians.

Q. Okay. So you have no medical training regarding what procedures may or may not be needed to perform—excuse me.

You have no medical training regarding what procedures may or may not need to be performed in an aseptic field?

A. Only, again, from what clients across the country have told me.

Q. And you have no training regarding sterilization or sanitation protocols as it relates to abortion services, correct?

A. No. Again, only from my relationship with clinics.

Q. And so your opinion that in aseptic surgical field is not needed for performing abortion is not based on any medical training or education, correct?

[74] A. I believe that's defined in the—the facility's guidelines as to what is—obviously, it's an important distinction.

MS. KANE: So I'm going to object as non-responsive.

Q. (BY MS. KANE) Your opinion is not based on any medical training or education?

A. No. I have no medical training.

Q. Now, you also opine that abortions are non-invasive procedures in paragraphs 23 and 24 of your testimony, correct?

A. I don't have that in front of me, but I'll trust your . .

Q. Do you recall whether or not you testified—

A. Say it again.

Q. You testified that, in your opinion, abortions are considered non-invasive procedures, correct?

A. Right. Right.

Q. Okay. And are you aware that there are different—you're aware that there are different types of abortions, including surgical abortions, correct?

A. Uh-huh.

Q. And you don't have any medical training or experience regarding whether that or surgical abortions or any other type of abortions may be considered an invasive procedure or not, correct?

A. I couldn't say offhand.

Q. Okay. And you don't have any medical training regarding [75] complications that may arise during an abortion, correct?

A. Not by training.

Q. Now, you also offer an opinion in your testimony that the application of ASC requirements to

abortion facilities is a departure from prevailing standards; is that correct?

A. I'm sorry?

Q. You offer an opinion in paragraph 26, and I—let me—it might help if I—

A. It would actually.

Q. —have a copy. And I'm going to try and see if I can put it on here.

A. Oh. Is it just coming up on the screen?

Q. It should be on your screen.

A. Wow. I need my other glasses for this.

THE COURT: It's all magic.

THE WITNESS: It is. There's something going on here.

A. Okay. What paragraph are you looking at?

Q. Okay. We're looking at paragraph 26. So hopefully this will help us follow along.

Now, you offer an opinion, I believe in paragraph 26. Are you able to read that?

A. Yes. I believe that.

Q. Okay.

A. Did I cause that to move in?

[76] Q. No. That is me, and I'm hoping to adjust this so you can see it as easily as possible.

Now, where you say that the ASC requirements are a departure from prevailing standards—I believe that's the last sentence of that paragraph.

A. Right.

Q. Now, when you say "prevailing standards," I believe your testimony is actually referring to the FGI guidelines that you cite in your testimony; is that correct?

A. It's that and what is typically done across the country in terms of whether or not abortions are performed in ASCs.

Q. Okay.

A. It's standard, particularly an earlier procedures, that they're not.

Q. But your—your testimony includes no studies or anything of that nature that talks about whether abortions are typically performed in ASCs or not, correct?

A. I have no studies to cite of that except, again, from the experience of working with a lot of clients who perform abortions.

Q. Okay. Now, are there any—are you aware of any FGI guideline that specifically recommends whether or not abortions should or should not be performed in an office procedure room?

A. I don't think in those terms specifically.

Q. Okay. So there's no FGI guideline that specifically [77] addresses the proper location for performing an abortion service?

A. I don't know for sure if that's addressed or not.

Q. Okay. And you didn't conduct a survey of all of the state standards regarding abortion facilities, did you?

A. No.

Q. Okay. And, in fact, you're aware there are at least some states that currently require that abortion services be performed in an ASC, correct?

A. Yes. In Virginia. Basically the laws that were passed there that are similar to yours.

Q. And I believe you mentioned another state. Illinois?

A. No. Michigan.

Q. Michigan. I'm sorry.

A. Michigan, yes.

Q. Now, you also offer an opinion that the ASC requirements depart from fire safety standards by not taking into account the number of patients at the facility performing abortions who may not be able to take action to self-preserve in case of an emergency; is that correct?

A. That is correct.

Q. Now, this opinion is based on your assumption that patients under care in a facility performing abortions would not be under general anesthesia or deep sedation and, therefore, they would have the ability to serve-preserve; is [78] that correct?

A. That's correct. And you're reading out the of NFPA 101, the fire code. They define other things besides sedation, whether, you know, if you're in an accident and you can't move and you can't get out of the facility or you're under some kind of surgery, that you can't preserve your own life. That's the distinction they're making. And it's a very significant distinction in terms of facilities.

Q. But you have no medical training yourself regarding whether the ability of a patient under other types of sedation such as local anesthesia may also need assistance in the event of an emergency, correct?

A. I'm sorry. You're speaking a little rapidly.

Q. You have no medical training yourself regarding whether patients under other types of sedation, such as local anesthesia, may also need assistance in the event of emergency, correct?

A. That's correct. This information is conveyed to me through doctors and providers who live up to certain anesthesiology standards as it regards to this. It's not a hit and miss, one by one, person. There are standards for this who define who is considered not capable of self-preservation.

This, by the way, is how architects operate. We are not experts in all the things we design. We rely on information that our clients have in their minds.

[79] Q. Now, you offer an opinion that the patient facilities do not currently meet the—sorry. The plaintiffs' facilities do not currently meet the new ASC guidelines; is that correct?

A. That's correct.

Q. But you're not offering an opinion in this case regarding whether the plaintiffs in this case might be able to lease a facility—an existing facility that meets ASC guidelines, correct?

A. That was not part of my study.

Q. And you're not offering an opinion as to whether or not the plaintiff facilities in this case may be able to purchase an existing facility that would meet the ASC guidelines?

A. I'm sorry. Is that different than the first question you asked me?

Q. I asked about leasing in the first question.

A. You mean an existing up and running facility.

Q. Yes.

A. As opposed to buying—

Q. Yes.

A. —a similar facility?

Q. Yes.

A. So you're talking something that's already certified as an ASC?

Q. I'm asking whether or not you're offering an opinion as to the cost that the plaintiffs might incur in either leasing or [80] buying an existing facility that might satisfy the ASC requirements.

A. No. And the reason for that is that it—it's totally dependent upon the neighborhood, what part of town you're in, whether it's actually meeting the current ASC requirements. It's kind of an open-ended question. So

Q. Okay. Now, you do provide an opinion regarding the estimated cost to renovate the plaintiffs' existing facilities to meet the ASC requirements or to build a new facility to comply with the ASC requirements; is that correct?

A. That's correct, yes.

Q. Okay. Now, I want to turn to one of the two tables that you have in your testimony. And I know they're a little bit difficult to read, and so I think I'm going to

A. That's good, actually.

Q. Can you read that?

A. Bring it back, please. Okay.

Q. We have a double whammy.

A. Can you move it if you move from one table to another, because right now I can read. It's legible.

Q. Okay. Now, this is—you've included two tables along with your direct testimony; is that correct?

A. That's correct.

Q. And these are the—essentially the background data that leads you to your conclusions regarding the costs of either [81] renovating or building a new ASC for each of the plaintiffs' facilities; is that correct?

A. Well, table 1 is sort of a generic pass at—several generic approaches. Table 2 is actually looking at analysis of the three where, as I've mentioned in the report, it's a little bit hypothetical because two of those you actually couldn't do this but space-wise you could. So there's really only one that would have any hope of solving this issue with an addition or remodeling. But the first table 1 is actually totally a different approach, not connected to a given facility, but generic approaches.

Q. Okay. Why don't we look at table 2 because we're talking about the individual facilities?

A. Okay.

Q. Now, I want to ask you first: You gave testimony in this case that you—in calculating kind of an estimated cost to comply, you estimated that the new facilities would be approximately 7,000 square feet?

A. That's correct.

Q. And that was based on your assumption that two operating rooms would be needed for the facility; is that correct?

A. That's correct.

Q. Now, the Texas law does not require two operating rooms, correct?

A. I'm aware of that.

[82] Q. And you did not do any calculations regarding estimated costs for renovating or building an ASC facility that had one operating room; is that correct?

A. No. It's an easy calculation to do, but that's not part of this analysis. It would literally be subtracting that room and applying the square foot cost to that room.

Q. Now, you're implying in your testimony that a one-operating room ASC would need approximately 6,650 square feet of space; is that correct?

A. Yes. That's basically subtracting one of the rooms from the overall program.

Q. Okay. But you did not conduct any research into whether existing ASCs in Texas with one operating room might be operating in a smaller square footage footprint than that, did you?

A. No. It's more expensive and less efficient to operate a single O.R. facility in the abortion realm.

Q. Okay. And I think you might have not understood my question.

You did not look into whether there are ASCs that already exist in Texas with one operating room that are smaller than 6,650 square feet?

A. No.

Q. And the ASC requirements themselves have no square footage requirement, do they?

[83] A. They have an operating room requirement. They've got widths of hallways.

Q. But they have no maximum square—

A. You mean total for the building?

Q. Yes. The ASC requirements that are at issue in this case have no maximum or minimum square footage requirement, do they?

A. No. That would apply—that wouldn't make any sense, for any building to do that.

Q. Now, in forming your opinion with respect to the numbers in table 2, there is a column about that lists cost per square foot; is that correct?

A. That's correct.

Q. And you basically—and tell me if I'm getting this wrong—you take your numbers of the estimated

square footage and you multiply them by cost per square foot for various elements to come up with your costs for the construction. Would that be a rough way of saying it?

A. Yes. That's correct.

Q. Okay. So the cost per square footage numbers that you use in these tables were supplied by another entity called Cummings Construction Management; correct?

A. That's correct.

Q. And is it true that Cummings actually drafted these tables for your use?

A. Yes. With input from me. I provided them with [84] information, and they gave me feedback on square footages and I actually assembled this chart.

Q. And your testimony does not include any explanation as to what methodology Cummings used in arriving at the cost per square footage numbers that are used in your calculations, correct?

A. This information, no. But this typical information is put together in a database, and that's how construction management companies operate. They keep a record of actually existing completed projects and their final cost and then put that into their database, so they've got—when someone asks the question—the way I did this would be virtually the same way I would do it if he was a client and came to me and said, I'm thinking about building an ASC.

What do you think it's going to cost? I wouldn't give you a number off the top of my head. I'd go to somebody who's got a good database of those projects and could provide—and, again, you understand these are averages—but that would put us in the right ballpark of what such a facility is going to cost.

Q. But to the extent my question is, you don't know what precise method Cummings used to arrive at these figures, you don't know that method, correct?

A. I don't know firsthand. I know they're a successful, large health care company that would have—tend to have an accurate database.

[85] Q. And it's also true that you don't know what underlying data was used by Cummings to calculate the cost per square footage numbers that are used in this table?

A. You mean how many or what kind of facilities were evaluated.

Q. Any of the underlying data, correct.

A. Not firsthand. Again, they wouldn't be in business if they did this badly.

Q. And you didn't run your own calculations to determine if the data Cummings gave you was accurate?

A. I did some checks. Not personally I didn't do it because I wouldn't trust an architect to do that.

Q. Okay.

A. But I checked with the contractor that completed one of these facilities about four years ago and had actual cost data from what it costs to build the facility. It wasn't an estimate. It was the actual cost of doing that project.

Q. And that contractor—or that person was not located in Texas, correct?

A. They were in Illinois.

Q. Okay. And you did not do any independent research into the average cost of construction for an ASC in Texas, correct? A. That's—well, to the extent that that's incorporated in some of this data, there's health care that's built into this that's been performed in Texas, though.

[86] Q. But to the extent my question is, you yourself did not do any independent research into the average cost of constructing an ASC in Texas, that is correct?

A. That's correct. And there's a reason for that. Anecdotal information typically collected on an ad hoc basis is much less reliable than working out of a database of someone that does this every day.

Q. Now, you didn't contact any existing ASCs in Texas that perform abortions to ask them their cost for construction, correct?

A. No, I did not.

Q. And you didn't contact any other existing ASCs in Texas before rendering the opinions that you render in your testimony; is that correct?

A. I'm sorry. Say that again.

Q. You didn't contact—before you rendered the opinions that are in your testimony, you didn't contact any other ASCs in Texas to ask them about their construction costs either; is that correct?

A. That's correct. But, again, did I misunderstand your first question or was that the same.

Q. It was—I was rewording the question. Thank you.

A. Okay.

Q. Now, you agree that construction costs can vary depending on location?

[87] A. I'm sorry?

Q. You agree that construction costs can vary depending on location?

A. Yes. Absolutely.

Q. And you do not know whether the numbers that were given to you by Cummings were adjusted for purposes of the locations that are at issue in this case, such as McAllen or El Paso, correct?

A. That's correct. I doubt that they were adjusted within Texas. I'm fairly certain they were adjust-

ed—if they used numbers beyond Texas, they were adjusted for the construction climate in Texas.

Q. But you don't know—

A. That's typical.

Q. Okay. But you don't know for sure?

A. No, I don't.

Q. And you do not know whether the numbers you were given were based on costs associated with construction only in Texas, correct? Those numbers might have included construction that occurred outside of Texas?

A. Typically a database like this would be collected from a broader area and then adjusted for a local building climate.

Q. And, in fact, the person you worked with from Cummings who gave this data to you is based in Denver, Colorado; is that correct?

[88] A. That's correct.

Q. And as far as you're aware, the numbers could have been based on data occurring outside the State, correct?

A. I suspect it was and adjusted to the Texas building climate.

MS. KANE: Okay. Thank you, Mr. Johannes. No further questions.

THE WITNESS: Thank you.

THE COURT: Redirect?

MR. LAWRENCE: Thank you, Your Honor.

REDIRECT EXAMINATION

BY MR. LAWRENCE:

Q. Mr. Johannes, you were asked on cross-examination about your experience with construction of health care facilities.

In about how many states have you been involved in constructing and providing services for constructing health care facilities.

A. In consulting, probably one two, three, four—probably five or six.

Q. You don't know off the top of your head where those states are?

A. I'm sorry.

Q. Which states those are?

A. Well, I did consulting to Virginia on seven clinics and seven in Michigan. I did some consulting in Kansas on a [89] similar basis. My firm designed an ASC in Granite City, Illinois. And I've done other health care work with other firms over the years in Colorado and Missouri.

Q. Mr. Johannes, do you have any affiliation with any university?

A. Yes, I do.

Q. What is that?

A. Washington University in St. Louis. I teach the professional practice curriculum in the School of Architecture.

Q. And how long have you done that?

A. For about 20 years, exactly.

Q. Mr. Johannes, on cross-examination you were asked a question—it was brief, but you were asked a question about your relationship with—any relationship you had with one of the plaintiffs in this case, Ms. Hagstrom Miller?

A. Yes.

Q. How many times have you been in Ms. Hagstrom Miller's presence—personally in her presence?

A. Usually it's been limited to once a year at a NAF meeting, because she's a member there.

Q. Mr. Johannes, you talked about—during the cross-examination you were asked some questions about the grandfathering and waiver process. Why is that important?

A. Well, in terms of developing a predictable and attractive business climate, predictability—predictability is a very [90] major thing if you're looking to invest in any place, a city or a state. And

you'd like to know when you go to your bank to do a business plan that if you project out 10 years, that three years out the laws aren't going to change requiring you to redesign all or a big chunk of your building or maybe what you're doing there isn't going to be legal anymore. So—but you don't want to use that as a reason not to change laws if there's a good reason to do it.

So typically when laws change, more information becomes available—and I'm not talking about just health care. I'm talking about any kind of building—where you want to modify the laws that are on the books, you don't go back and ask an existing facility to basically rip themselves up and provide those changes because, literally, the codes typically change—they're revised every three years. So you could literally be under construction on a continual basis just trying to keep up with the latest code changes. I wouldn't invest in a place that required that of me because I would have no predictability whatsoever.

Q. Mr. Johannes, you've testified about a 7,000 square foot requirement to meet the requirements of the ASC, requirements under the Act. How did you reach that number?

A. Actually, that's based upon the facility that's in my deposition that I referred to, which is an existing clinic that was built in Illinois which in my estimation comes very, very [91] close to meeting exactly

what it appears Texas is looking for from their ASC regulations. And that was 6900 square feet.

Because it wasn't an abortion clinic, it doesn't include counseling, which most—most clinics have a number of rooms for counseling patients. So I rounded that up to 7,000 square feet. It does include a second O.R. And without a second O.R.—I'm sorry. Should I continue?

Q. If you would, could you tell us why a second O.R. is important?

A. Yeah. It's an issue of efficiency, basically, of operation. An abortion takes seven to eight minutes to perform, typically, and it takes about seven to eight minutes to prepare the room for the next patient. So, basically, you've got about 50 percent downtime if you've only got one operating room to operate out of.

What that means is that, basically, the medical costs virtually double, right, because you've got twice as much time to accomplish the—twice as much fee to accomplish the same work and the women that are sitting in the waiting room waiting for their abortion are going to be sitting there twice as long.

So one of the things about abortions, because it is a short procedure, it's important to be able to move from one room to the other while it is being prepared and the other one is actually serving the client. It's a little different in an ASC if you're doing a procedure that lasts an hour and a half. [92] It's more critical when you're talking about an abortion facility.

Q. And on cross-examination you were asked some questions about ASCs in the State of Texas that may have one operating room. In what context would one operating room make sense?

A. I think where you had longer procedures, certainly. I'm not even sure then it totally makes sense. But I think the impact of that is less on the cost of the clients and the cost to the patients and the cost to the facility if you've got procedures that typically last an hour and a half and then you flip the room in seven minutes to get it ready for the next patient. But when you're operating at the rate of seven to eight minutes per procedure, that's half of your time.

Q. And, Mr. Johannes, you were asked on cross-examination about some ASCs—non-abortion ASCs in the State of Texas that are less than 7,000 square feet. Is it your—what is your understanding about the application of grandfathering and waivers to non-abortion ASCs in the State of Texas?

A. I understand that it's allowed in non-abortion ASCs. So in answer to that question, they may or may not. Since grandfathering seems to be allowed if it's not an abortion clinic, the hypothetical examples that were mentioned may or may not. I have no way of knowing whether they meet the standards or whether they've been grandfathered or granted waivers. It would be obviously impossible to know.

[93] Q. Now, Mr. Johannes, you were asked some questions about a Cummings on cross-examination. Can you tell us just what is Cummings?

A. It's a construction management company. Would you like me to elaborate on what that means?

Q. Please do.

A. Basically without getting into the whole history of it, there are firms that used to evolve out of contractor firms 30 years ago, but now they're coming from other places, who basically manage cost control, manage cost estimating, manage scheduling of projects. Very often they're hired first, and they will help hire an architect and an engineering team for the project.

But the initial value that they provide is that they're giving some cost opinion to clients when they're considering whether or not to proceed with a given project. And they do that out of a database, as opposed to a contractor who, you know, would want a full set of construction documents, which would be very expensive, before they even offer a price. CMs are specifically set up to provide that early information.

Q. And in working with Cummings to get the information out of the database that you did, did you tell them that you were looking at projects in the State of Texas?

A. Oh, yeah. Absolutely.

Q. And what is your understanding of how these databases work [94] with respect to projects within a specific state?

A. Well, typically the way they're built is that they're—they collect information about projects that have actually been built. So it's not crystal-balling. It's actually looking at a series of projects and getting documentation of those projects, understanding somewhat about the specifics of them, and then plugging them into their database and running a few math equations, and you could easily come up with a range of what the square foot cost is going to be for a given facility.

Then if the basis of that information is beyond a specific locale, which it typically would be, you're factoring in the state. So New York is going to be way higher than St. Louis, and Texas is probably going to be 5, 10 percent less than St. Louis. That's—but they know that. When they put that into their database, they're not providing a New York price to a facility in Texas.

Q. So it's your understanding that the cost per square foot that you used reflects a Texas price and not a New York price?

A. Yeah. Yeah. Right.

Q. Mr. Johannes, you were asked a question on cross-examination about a discussion you had with a contractor in Illinois about an ASC facility. Do you remember that?

A. Yes.

Q. What was the cost per square foot for the facility that you had the discussion with?

[95] A. I believe that one was, I want to say, $335 a square foot, I believe.

Q. And how many square foot was the facility?

A. 6900.

Q. Can you do the math for me what the total is?

A. What the total was?

Q. Yes.

A. The construction cost for the building I think was 2.3. And then on top of that were the soft costs of equipment and whatnot. So the project was—you're going to catch me on my math here, but it's somewhere in the range of $3 million. And that was four years ago.

I did a little—if you want one more example which we haven't talked about, but I did a little back checking on a clinic we designed in Illinois and adjusted for inflation. That was completed in, I think, '99. It was started by '97. Adjusted for inflation, that would be about $325 a square foot right now.

Q. And, Mr. Johannes, if you're—you were asked some questions about table 1 of your—of your direct testimony. Can you—I guess I can try that

same trick that was tried. I don't know if I'm going to have the same luck with it.

A. I lost the header. The numbers are clear, but I don't know what they're referring to.

Q. Mr. Johannes, can you just tell us what option one is up [96] at the top?

A. Yeah. Option one is simply saying there's no way to fix their facility. We'll start over from scratch. So we're going to find us—I'm sorry about the jargon, but we use a green field. It's a green field. We're going to start with a piece of land that has no building on it or a piece of land where we tear down the building and we build a brand new facility from scratch.

Q. And based on your experience and the work you did in this case, to start from a green field from scratch and to build an ASC that would meet the Texas requirements, how much would that cost?

A. The building would be about 2.3 million, and the soft costs would get that number up for the project cost to about 3.3 million.

Q. When you say "soft costs," what do you mean?

A. These are the costs that typically don't end up residing in the building after the building is complete. So they include fees—well, some of them reside in the building—it would include furniture, equipment, things that aren't attached to the building, per se, permits. If there's any specialized consult-

ing to it, but certainly the architect and engineering fees would be included in the soft cost.

Q. And soft costs, those are real costs?

A. They're real costs. Yeah. I'm not sure why they're [97] called soft costs because you've got to write a check for them

Q. And you have a line here, and it's—let me see if I can go over it a little bit. It's line 12, land acquisition.

A. Yes.

Q. Part of the soft costs?

A. Yeah. And that's not included in any of these numbers because, again, depending on the neighborhood, depending on where you found the site, that could be virtually anything, from a very large number per acre to not so much. So I had no way of fairly putting that into these numbers without making them look misleading.

Q. But it's fair to say you have to write a check for that as well?

A. You sure do.

Q. If you can tell us what option two is, Mr. Johannes.

A. This is where—this, in essence, is the basis of table 2, applying it more specifically to actual clinics. This is where you would say, Okay. We've got

4,000 square feet of building now. We believe that the program is going to require about 7,000. So, obviously, the math tells you that you need to put an addition on the building.

So this is looking at what if we put a 3,000 square foot building on a hypothetical 4,000 square foot existing facility. What would that cost? And the prices—the unit prices, as you can see, are very different.

[98] Q. And why is that?

A. Well, the new portion would—what we call the addition is probably going to be per square foot a little higher than new construction because of the economies of scale, that if you do a tiny building, per square foot it's going to be more expensive than if you do a big building.

But then the interior redesign of the existing portion of the facility, now you've got the roof, you've got the walls, you've got doors, and you've got windows. So, you know, you're out of the rain. So now we're basically taking out what's there and bringing that up to the Texas standards within that shell. So that's going to be a smaller number than it would be from starting from scratch in the interior—in the remodel portion only. The addition, of course, would be virtually new construction.

Q. And, Mr. Johannes, what do you—what do you come up with the total project cost for that option two?

A. I think the building cost—it's a little fuzzy, but I think it's at 1.4. And, again, with soft costs, that gets up to—I'm sorry. I'm having a hard time. Is that—I can't read the bottom number.

Q. My apologies. Maybe we can get you a hard copy of the document so that you can just see the number without it being blown up.

A. I think it's 2.181.

[99] Q. Well, I'll give it to you so you don't have to strain?

A. Okay. Yeah. That's 2,181,000.

Q. And, Mr. Johannes, tell us a little bit about what option three is?

A. Three is, if you could find a shopping mall that would entertain an abortion clinic as a client, you go in and the space has never been occupied and it's a developers who's put up a building—an office building of some sort, it probably has a rock floor. That's the way a typical development is done these days. But you're in a container. You've got walls; you've got a roof. So you basically go into that space and put a custom use in that tenant space. So that's what that's reflecting.

So if you look at the top portion of this, we no longer have a new shell and core number because that's already provided by the developer. So now we're looking at just turning that space into an ASC.

Q. And what are the construction costs on a project like that?

A. The estimate here is 1.4 for the hard costs and then 703 I think, or 02, for the soft costs, which the total is 2.1 million.

Q. And can you just tell us a little bit about option four, what that is?

A. Option four is assuming that you find a building that's [100] been—and re-purpose it, if you'll pardon the jargon. It's been used for something else but, again, it's got the roof, it's got concrete floors, it's got some form of plumbing some form of HVAC. But you're basically either buying or renting that building, gutting it entirely, and then converting it to a Texas complying ASC within that appropriate size shell.

Q. And what are the construction costs on a project like that, Mr. Johannes?

A. The hard costs, hundred—I'm sorry—1,100,0000, soft costs of—I think that's 500,000.

Q. What's the total project cost on it?

A. Total cost is $1.7 million.

Q. Mr. Johannes, on direct you were—I mean, on cross you were also asked some questions about your table two.

A. Yes.

Q. Mr. Johannes, what is the WWH Austin column? What does that refer to?

A. That's referring to the Whole Woman's Health in Austin.

Q. Have you been—as part of your work, did you go to that facility?

A. Yeah. That was one of the clinics I visited, yes.

Q. Can you explain to us what this project here represented in the chart reflects for the WWH Austin project?

A. Well, I believe the 3400 is the current size of the facility. So assuming that we're looking at a program of 7,000 [101] feet, just the math of that would give us 3,600 square foot addition that we'd have to provide. And, again, in the addition we're looking at virtually new construction. And in the remodel portion we're looking at remodeling the existing shell. So this is the second column on the previous chart that applies specifically to that clinic.

Q. And what are the construction costs that you come up with for this Whole Woman's Health Austin project?

A. Hard—again, hard costs, the construction costs, is 1.6, and the total is $2.4 million.

Q. So the $2.4 million, that represents the cost it would—it would take for this clinic to get into compliance with the ASC requirement?

A. That's correct.

Q. And can you explain to us what the WWH Fort Worth column reflects?

A. This is the Whole Woman's Health clinic in Fort Worth. Again, that particular building is small. It's 2950, I think, in its current configuration. So there we'd be putting on about a 4,000 square foot addition to provide the required space. And that would get us to about $2.6 million for that approach on that particular building.

Q. And—and the last column, the Reproductive Services El Paso?

A. Same process for the facility.

[102] Q. What is Reproductive Services El Paso?

A. That's an abortion clinic in El Paso. It's currently closed, but it's—it's the biggest of the buildings that I toured. This one I think was 5600. So the addition to that one would be much smaller than the other facilities. So we would be doing a lot more rehab within the existing facility and a smaller new—new construction.

Just a general comment about these—and, again, this is just whether exactly this would work this way. But to be fair to the analysis, we assumed the more expensive medical related stuff would be in the new addition because it's going to be easier and cheaper to do there than try to carve that into an existing building. And things like waiting rooms and offices that

are going to be less problematic we would put in the old building because it would be less expensive. As an architect, that's one of the first things we look at, is how much of this can we put in in the most economical possible way.

Q. And so what were the total projection costs to bring the Reproductive Services in El Paso up to compliance with the new ASC requirements?

A. 1.6 million.

Q. And why is that lower than the other two?

A. The shell is bigger. The shell is 5600 square feet as opposed to the other two. So, basically, you've got—and, again, this makes a lot of assumptions, like does the roof leak [103] or not leak. But if you assume that you've got a shell that has integrity, then you can go ahead and treat that as a remodeling cost rather than new cost. And the piece that would be new and more expensive is much smaller here than it is for the other two examples.

Q. And is it your understanding that any of these facilities would actually be able to do this work within the structure that you actually surveyed?

A. No. This is somewhat of a thought exercise, as they say. Fort Worth has the room, and I believe that's an owned facility. Austin I think is a rental facility with other medical and nonmedical tenants, you know, with a prearranged parking lot and curbs and landscaping. So the likelihood that anyone would allow that—this to happen in Austin is unlikely.

In El Paso there probably would be room on the site to do it, but my understanding is that this facility is not actually at this point a possibility because it's—I don't think it's open or owned necessarily anymore.

Q. When you say not owned anymore, it's not owned by—the facility doesn't own it?

A. Yeah. I'm not positive of that, but I understand that this actually couldn't happen either in El Paso.

Q. Mr. Johannes, you were asked on cross-examination whether you had looked at what it would cost to buy an existing ASC, [104] correct?

A. That was the question, yeah. And I did not. But a few things about that, I think I already said that it's a hard thing to ascertain because it depends on the neighborhood and the land value of the particular site. In addition to that, it's not like that would be a freebie. It's already there, so you get a deal on it. Somebody has built that building and put those facilities in place. And when they turn around to sell it for whatever reason they're getting rid of their ASC, they're going to want to get that money back. So, fundamentally, you're going to be paying for it as a purchase rather than paying for it as a construction. But it doesn't, like, go away because you find one.

Q. So if its costs $3 million to build a facility, what would—what does that leave you to expect about buying one?

A. It depends on real estate values. If you've got 3 million in it and the values have gone up, you might sell it for 3 million-6 and make a profit at it. If the area is depressed, you might get it for 100,000, 200,000 dollars less.

Again, you—the seller would want to recoup most of what they put into that building to get it to that compliance level. And the other thing in that hypothetical, you know, the question is, has it been grandfathered under the old ASC law? Are you going to have to go in after you buy it and spend some more money to now bring it up to the current standards? Which [105] the way the current law is structured, the answer to that would be yes. I mean, anything that's not compliant with a transfer in ownership, grandfathering is not going to be honored. So you'd basically be bringing that facility up to speed. So it conceivably could be more expensive than building new, where you were doing everything correctly.

Q. And for a $3 million building, what does that tell you about leasing it?

A. Well, you mean, same question but if you were leasing rather than buying? Same issue. I mean, if anybody has put this money into it and they want to keep ownership of it but want to lease it to a new client, they're obviously going to want to get their money back through the lease rate. So it's not going to be inexpensive.

MR. LAWRENCE: Your Honor, I have no further questions.

THE COURT: Ms. Kane, recross.

MS. KANE: Briefly, Your Honor.

RECROSS-EXAMINATION

BY MS. KANE:

Q. Mr. Johannes, just to clarify a few things for me.

A. Sure.

Q. On the tables, other than the square footage numbers that are listed on the tables, the data that is used to calculate the costs, including this cost for square footage and the soft [106] costs were provided to you by Cummings, correct?

A. That's correct.

Q. On both charts; is that correct?

A. Yes. I provided them with my assumptions about the size of an addition, what would be remodeling, what would be new, and then they cost those as components of the construction.

Q. Now, I believe you told the plaintiffs' counsel that costs that were provided to you by Cummings were Texas costs, correct?

A. They were—I mean, they were adjusted to Texas costs. If it came from Arkansas and Texas is 5 percent more expensive, that would have been—typically, that would be factored in.

Q. But other than Cummings telling you that they adjusted them for Texas, do you have any other basis for knowing whether or not this data has been adjusted for construction costs in Texas?

A. No. I haven't checked up on it to make sure.

Q. So it would be correct that you relied entirely on Cummings' representation to you that these were Texas-based costs?

A. That and checking the costs against my own experience in the Midwest, that these are in line with a number of other metrics to measure whether this made sense or whether this was way out of whack or not.

Q. But, again, you have never designed or built a building in [107] Texas, correct?

A. That's correct.

Q. And, finally, you mentioned a distinction between two-operating room ASCs and one-operating room ASCs. And just to be clear, the opinions you were offering are not based on any medical background or training, correct?

A. No. They're just based on logic.

MS. KANE: Okay. Thank you.

THE COURT: Redirect?

MR. LAWRENCE: No, Your Honor. Mr. Johannes may step down.

THE COURT: You may step down.

All right. I think this is about as convenient a time to take our noon recess as there will be. So at this time we'll be in recess until 1:30.

(Recess)

(Open Court)

THE COURT: Plaintiffs may call their next witness.

MR. STEPHENS: Your Honor, before we start with the plaintiffs calling a witness, just one preliminary matter. The State would like to invoke the Rule as to any fact witnesses in the courtroom who may be called by the plaintiffs.

THE COURT: Well, it will be sauce for the goose and sauce for the gander. So if there are any fact—does the Plaintiff have a response to that?

[108] MS. TOTI: Your Honor, all of our fact witnesses are parties.

THE COURT: Are what?

MS. TOTI: Parties. Plaintiffs.

THE COURT: Well, if they're parties, they're exempt from the Rule. Is there anyone else present in the courtroom known to you that will be a fact witness?

MS. TOTI: No, Your Honor. We have—our witnesses—all of our witness are either experts or parties.

THE COURT: All right. Then your experts will likewise be excused.

Is there anyone in the courtroom known to the State as potential fact witnesses?

MR. STEPHENS: No, Your Honor.

THE COURT: All right. The rule has been invoked as to fact witnesses, though. So I say to both of you, if there's any change in your plans or if anyone enters the courtroom that you believe will be a fact witness, you will instruct those witnesses that they are not to talk about this case among themselves or with anyone else. They are to remain outside the courtroom during the testimony of any other fact witness or until excused from the Rule by the Court. However, they may talk to the lawyers for either side.

MS. TOTI: Yes, Your Honor.

MR. STEPHENS: Yes, Your Honor.

[109] THE COURT: All right. Now you may proceed. Anything else, Mr. Stephens?

MR. STEPHENS: No. That's all.

THE COURT: All right. You may proceed.

MR. BROWN: Your Honor, the plaintiffs would now like to call Ms. Felix.

THE COURT: Pardon me. I didn't understand you. Who did you call?

Lucila Felix.

(Interpreter sworn)

(Witness sworn)

THE COURT: And would you remind me your name again, please.

MR. BROWN: My name is David Brown.

THE COURT: Thank you.

LUCILA C. FELIX,

having been first duly sworn, testified through the duly sworn interpreter as follows:

DIRECT EXAMINATION

BY MR. BROWN:

Q. Ms. Felix, would you please state your full name.

A. Lucila Ceballos Felix.

Q. Have you submitted a written direct testimony today?

A. Yes.

Q. And is that testimony a complete and accurate statement of [110] the opinions that you wish to offer?

A. Yes.

MR. BROWN: Plaintiffs, Your Honor, would like to move the direct testimony of Lucila Felix into evidence.

MR. SOTO: No objection, Your Honor.

THE COURT: All right. I am still having a little bit of trouble understanding you and the witness. The name of this witness is?

MR. BROWN: The witness is Lucila "Lucy" Ceballos Felix.

THE COURT: All right. Then, without objection, the document entitled Direct Testimony of Lucila "Lucy" Ceballos Felix that's previously been presented is admitted into evidence.

MR. BROWN: And we have nothing further on direct.

THE COURT: All right.

CROSS-EXAMINATION

BY MR. SOTO:

Q. Good afternoon, Ms. Felix?

A. Good afternoon.

Q. My name is Esteban Soto. I'm an Assistant Attorney General with the Office of the Attorney General. I'm going to ask you some questions this afternoon about your direct testimony.

A. Of course.

[111] Q. You haven't submitted a CV or resume in this case, have you?

A. No.

Q. You wrote an expert report in this case?

THE INTERPRETER: I'm sorry, sir?

Q. (BY MR. SOTO) You wrote an expert report in this case?

A. Yes.

Q. You didn't include a resume in that expert report?

A. No, sir.

Q. You have a bachelor's degree?

A. In Mexico, yes.

Q. You've never attained a postgraduate degree?

A. No.

Q. You're giving an opinion here today about the effects of House Bill 2; isn't that right?

THE INTERPRETER: About the effects? I'm sorry?

Q. (BY MR. SOTO) You're giving an opinion here today about the effects of House Bill 2?

A. Yes.

Q. You claim the restrictions found in House Bill 2 will cause clinics in the Rio Grande Valley to close?

A. Correct.

Q. However, at the time you reached your conclusions in this case, you didn't have any knowledge about what provisions were contained in House Bill 2?

[112] A. I started investigating more about it. I got more interested in it, and that's how I found out about it.

Q. But at the time—do you recall you gave a deposition in this case?

A. Yes. Back then I didn't know the details. Now I know a little bit more.

Q. And you submitted your expert report before that deposition; isn't that right?

A. Yes.

Q. And when did you start to investigate what was in House Bill 2?

A. After—after my deposition.

Q. You base that—you base your opinions on the effects of House Bill 2 on the fact that two abortion clinics have closed since House Bill 2 has passed?

A. Yes.

Q. Have you ever heard the saying "correlation doesn't imply causation"?

A. What's that? I don't understand.

Q. Have you ever heard the saying "correlation doesn't imply causation"?

A. No.

Q. You're not a scientist?

A. No.

Q. You're not an academic?

[113] A. No. I'm not an attorney either.

Q. You've never been published in a peer-reviewed academic journal?

A. No.

Q. In coming to your conclusions in this case, you rely almost exclusively on conversations with anonymous sources?

A. I don't understand.

Q. Your opinions are based on conversations with women in the Rio Grande Valley?

A. With whom? I'm sorry.

Q. Your opinions are based on conversations with women from the Rio Grande Valley?

A. Yes.

Q. The identities of those women haven't been disclosed?

THE INTERPRETER: I'm sorry?

Q. The identities of those women haven't been disclosed?

A. No.

Q. None of those women are testifying for themselves in this case?

A. No, sir.

Q. To relay what these women tell you, you're only relying on your memory?

A. Yes.

Q. You base your opinions on your personal observations?

A. Yes. Based on observations and stories that I have heard [114] from these women.

Q. So you also base your opinions on anecdotes from your conversations from these women?

A. Yes.

Q. You didn't collect any data?

A. No, sir.

Q. You didn't review any scientific literature?

A. No, sir.

Q. You didn't do any statistical analysis?

A. No.

Q. You didn't do any scientific analysis?

A. No, sir.

Q. The majority of women you spoke to from the Rio Grande Valley live below the poverty line?

A. Yes.

Q. Not all women in the Rio Grande Valley live below the poverty line; isn't that correct?

A. Not all the women.

Q. In fact, the majority of women in the Rio Grande Valley live above the poverty line?

A. Let me clarify. The majority of the women that I work with are in extreme poverty, but that doesn't mean that all of the women I talked to are poor.

Q. You claim that no public transportation exists between McAllen and San Antonio?

[115] THE INTERPRETER: I'm sorry, sir?

Q. (BY MR. SOTO) You claim that no public transportation exists between McAllen and San Antonio?

A. Yes.

Q. You define "public transportation" as mass transit operated by the government?

A. I know that there is transportation via Greyhound, but for something that is of low cost for women to go from McAllen to San Antonio is nonexistent.

Q. Greyhound costs about $75 round trip—

THE INTERPRETER: $25?

Q. (BY MR. SOTO)—$75 from McAllen to San Antonio?

A. Yes.

Q. It takes about 3.5 hours to drive from McAllen to San Antonio?

A. More or less.

Q. And Corpus Christi is about 150 miles away from McAllen; isn't that right?

A. I really don't know from McAllen to Corpus Christi, but McAllen to San Antonio is like 450 miles.

Q. I'm sorry. Can you repeat that?

A. Well, you're asking me how many miles are between McAllen and Corpus. I really don't know how many miles there are.

Q. Okay. And how far is it from McAllen to San Antonio?

A. It's about 470 miles. More or less about three and a half [116] hours each way by car.

Q. You're basing your opinion on your belief that San Antonio is 410 miles from McAllen?

A. 470.

Q. 470. Your opinion in this case is based on your belief that San Antonio is 470 miles away from McAllen?

A. Yes.

Q. Do you know how long it takes to drive from McAllen to Corpus?

A. If I'm not mistaken, I think about two hours. I don't have it in my testimony.

Q. You're aware, until very recently, there was an abortion clinic in Corpus Christi?

A. There was one. It's no longer there.

Q. If a patient from McAllen had to drive to Corpus Christi to get an abortion, she would have to travel between four or five hours by car?

A. To Corpus?

Q. To Corpus round trip.

A. Even—it was difficult even if there was a clinic there because there was the challenge of transportation for the women.

Q. So women who had to travel to Corpus already experienced some of the challenges that they would have going to San Antonio; isn't that right?

[117] A. Yes. It would be the same challenge.

Q. She'd have to try and find transportation?

A. Not only look for transportation, but somebody to take care of their children. There's other challenges, but the transportation is the main one.

Q. So if a woman had to travel from McAllen to Corpus Christi and she had kids, she would have to find child care?

A. Exactly. They have to find somebody to take care of them and pay or take them with them. And, besides, they have to ask for permission at work. There's a number of challenges that these women are faced with.

Q. So that was my next question. If she worked and she had to travel from McAllen to Corpus Christi for an abortion, she would have to take the day off work?

THE INTERPRETER: That she would have to do what?

Q. (BY MR. SOTO) If a woman had to travel from McAllen to Corpus Christi and she worked, she would have to take the day off of work?

A. Exactly.

Q. And if she took the bus, she'd have to pay for tickets?

A. She would have to pay for the ticket plus all of the other challenges that she is faced with.

Q. And if she drove a car, she would have to pay for 300 miles worth of gas?

A. To where? To Corpus?

[118] Q. To Corpus Christi.

A. Well, I don't know the mileage. I'm sorry. About that she would have to pay and have to drive there, and that's very expensive for most women—for many women.

Q. You work in Brownsville?

A. I work in the four Rio Grande Valley colonies and some other cities outside the Valley.

Q. You're familiar with Brownsville?

A. Yes. I live there.

Q. Brownsville is located in the Rio Grande Valley?

A. Yes.

Q. It's actually the biggest city in the Rio Grande Valley?

A. We could say so.

Q. Brownsville is about 60 miles away from McAllen?

A. Yes. More or less.

Q. It's about an hour drive one way?

A. Yes. More or less, yes.

Q. So that means, if a woman or a patient wanted to travel to—from Brownsville to McAllen for abortion, she would have to travel two hours round trip?

A. Yeah. But we had the clinic in Harlingen that was closer.

Q. But I'm asking about specifically traveling from Brownsville to McAllen. That's about two hours round trip?

A. Correct.

Q. Are you aware that in Texas, before a patient gets an [119] abortion, she has to have an ultrasound?

A. Yes.

Q. That ultrasound typically has to occur at least 24 hours before the abortion; isn't that right?

A. Yes.

Q. So, for instance, if a patient has to travel from Brownsville to McAllen to get an abortion, she has to make that trip twice?

A. Exactly.

Q. Once for the ultrasound?

A. And, depending, more time that might be required.

Q. And then on another day she has to go for an abortion?

A. Yes.

Q. That means that a Brownsville patient getting an abortion in McAllen, in order to get an ultrasound and an abortion, has to travel 240 miles round trip?

A. I don't know the miles. But I know it's about 60 miles. It would be about 120.

Q. For one trip. For two trips is about twice that, so about 240?

A. Yes.

Q. She has to find transportation on two different days?

A. Yes.

Q. If she rides the bus, she has to buy two round-trip bus tickets?

[120] A. To McAllen?

Q. Yes.

A. Yes.

Q. If she works, she has to take time off work on two different days?

A. Yes.

Q. And if she has children, she has to find child care on two different days?

A. Correct.

Q. Are you aware that there is an exception to the law mandating the 24-hour waiting period between an ultrasound and abortion if the patient doesn't live within 100 miles of an abortion clinic?

A. I really didn't know.

MR. SOTO: We'll pass the witness, Your Honor.

THE COURT: Redirect?

MR. BROWN: Thank you, Your Honor. Just a few questions on redirect.

REDIRECT EXAMINATION

BY MR. BROWN:

Q. In your direct testimony you say you are a *promotora* or a community health worker; is that correct?

A. Yes.

Q. What do you do as a *promotora*?

A. A health promoter works as a bridge between the community [121] and the health services.

Q. And what do you mean by "a bridge"?

A. That person informs and educates regarding health and also brings the resources closer.

Q. Do you help bring health care resources to women?

A. We take information about the resources. Exactly.

Q. So do you help women to access health care resources?

A. Yes.

Q. How long have you been doing this?

A. Since '97—since 1997 to date.

Q. Can you estimate approximately how many women you have worked with as *promotora* during that time?

A. With how many *promotors*, there's too many—there's too many promoters and health workers that I have worked with since 1997 to date.

Q. Can you tell me how many women in total you have worked with as a *promotora* since 1997?

A. It's thousands of women.

Q. Are you certified by the State as a *promotora*?

A. Yes.

Q. Are you offering your opinions today based on your experience as a *promotora*?

A. Yes.

Q. At the time that you submitted your expert report, did you know all of the abortion clinics in the Rio Grande Valley were [122] closed?

MR. SOTO: Objection. Leading, Your Honor.

THE COURT: Overruled.

A. Yes.

MR. BROWN: I have nothing further, Your Honor.

THE COURT: Recross, Mr. Soto?

MR. SOTO: No questions, Your Honor.

THE COURT: You may step down.

MS. BHANDARI: Good afternoon, Your Honor, Esha Bhandari for the plaintiffs. The plaintiffs would like to call Kristine Hopkins to the stand.

THE COURT: Please come forward.

(Witness sworn)

KRISTINE HOPKINS,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. BHANDARI:

Q. Dr. Hopkins, please state your full name for the record.

A. My name is Kristine Hopkins.

Q. Did you submit a declaration that contained your direct testimony in this case?

A. Yes, I did.

Q. And was that written declaration a complete and accurate statement of your testimony in this case?

A. Yes.

[123] MS. BHANDARI: At this time Plaintiffs would like to move for the admission of the direct testimony of Kristine Hopkins into evidence.

MR. SOTO: Your Honor, we filed a Daubert motion on Ms. Hopkins last week. We'd like to re-urge that just to preserve our 702 objection. But, otherwise, we don't object.

THE COURT: The court has read and reviewed the motion that was filed last week that we also discussed briefly in the pretrial conference on Friday. I know you-all were trying to work out your problems with the expert testimony. Having reviewed the objections to this witness's testimony and the Daubert motion, I find that they are all matters that go to the weight of the testimony, not the admissibility

under the precepts set forth in Daubert, all of which I have reviewed. The Daubert motion with regard to this witness will be denied. Do you have further objection to the direct testimony by her?

MR. SOTO: No we do not, Your Honor.

THE COURT: Then at this time the Court admits into evidence the declaration entitled Direct Testimony of Kristine Hopkins, Ph.D.

MS. BHANDARI: No further questions on direct.

THE COURT: Mr. Soto, cross-examination?

MR. SOTO: Thank you, Your Honor.

* * *

[124] **CROSS–EXAMINATION**

BY MR. SOTO:

Q. Good afternoon, Dr. Hopkins?

A. Good afternoon, Mr. Soto.

Q. Dr. Hopkins, your opinions today focus on women of reproductive age in the Rio Grande Valley and El Paso?

A. That's correct. And—yes. That's correct.

Q. Okay. No other areas, right?

A. That's correct.

Q. Okay. And, just for clarification, are you offering the opinion that the social and economic disadvantage experienced by women in these two communities would cause them to experience difficulties in traveling outside the region to access abortion care?

A. I'm sorry. Would you repeat the question, please?

Q. Are you offering the opinion that the social and economic disadvantage experienced by women in these two communities would cause them to experience difficulties in traveling outside the region to access abortion care?

A. I offer the opinion that a large number of women, because of the social and economic disadvantage that experience, women of reproductive age, would experience difficulties overcoming the barriers to access abortion care outside of their communities.

Q. So their level of disadvantage would cause them to [125] experience difficulties traveling outside the region to access abortion care?

A. That women who live in poverty and women who are uninsured have a higher rate of—they're more likely to experience—more likely to have difficulties to overcome the barriers to travel the distance that would be required compared to women who don't live in poverty or who have insurance.

Q. Do you believe there's a causal link between social and economic disadvantage and women's ability to access medical care outside of the region?

A. I'm not clear what you mean by causal link in this case.

Q. Do you believe that their social and economic disadvantage would cause them to experience difficulties traveling outside the region to access abortion care?

A. I argue that the social and economic disadvantage leads to—that large numbers of women would be more likely to have difficulties overcoming the barriers to access abortion care outside of the communities.

Q. I think we're agreeing with each other. You're saying that the disadvantage would lead to them having difficulties traveling outside the region?

A. Yes. Large numbers of women, yes.

Q. Do you believe that a large body of academic literature supports the opinion?

A. Yes.

[126] Q. Did you review your direct testimony prior to today?

A. Yes.

Q. In your written direct testimony, do you mention any studies or articles from that large body of literature?

A. No. But in my deposition I mentioned the—that some of those studies are reviewed in Kaiser Reproductive Health—Kaiser Family Foundation. And those studies—I went back to review those studies, and they are Ward, et al., 2008 and CA—*Cancer Journal for Clinicians*.

The—they also reported data analysis that the Kaiser commissioned on Medicaid and the uninsured, had calculated and analyzed based on the National Health Interview Survey. And two additional citations from that literature are Juan, et al., 2005 from *Ambulatory Pediatrics* and Schoen and DesRoches, 2000, in the *Journal of Health Services Research*.

Q. Did you cite any of those articles in your expert report?

A. No, I did not.

Q. When you were asked at your deposition, could you identify any single specific article or study from that large body of literature?

A. No. I referred to the Kaiser Family Foundation which summarized the first two citations I mentioned.

Q. But you couldn't identify the article name or the study's name?

A. Not at the time of the deposition, no.

[127] Q. And a couple of weeks has passed since that deposition; isn't that right?

A. That's correct.

Q. Did you amend your expert report to include any of the citations you just mentioned?

A. No, I did not. I noted in my expert report that I—in my declaration that I was basing my expert opinion on my knowledge of the literature in the fields of sociology, demography, and reproductive health.

Q. But you didn't disclose any of those articles, did you?

A. That is correct.

Q. And you relied on this—your knowledge of this large body of literature to come to your opinion in this case?

A. That is correct.

Q. I'm sorry. What was that?

A. That is correct.

Q. Okay. You also relied on your—on prior field work?

A. That is correct. Well, I relied on, again, my knowledge of the—of the field in reproductive health, of which one of those was my prior field work.

Q. And, specifically, field work dealing with contraceptive services?

A. That's correct.

Q. That field work hasn't been published yet?

A. I have since submitted that manuscript for publication, [128] and it's currently under peer review.

Q. It has not passed peer review?

A. That is correct. It takes some time. I just submitted it two weeks ago.

Q. That was after the deposition?

A. That's correct. It was under—as I mentioned during the deposition, it was under preparation in manuscript form.

Q. In your expert report, you didn't cite any data from that field work?

A. That is correct.

Q. In that expert report you didn't discuss how that field work influenced your conclusions in this case?

A. Insofar as I mentioned that drawing upon my large experience in the fields of social and demography and reproductive health.

Q. And that's the only time you mentioned your field work in the entire expert report?

A. That is correct. I did mention the field work specifically, as I mentioned.

Q. That field work didn't specifically impact your conclusion in this case?

A. No.

Q. And your knowledge of that large body of literature and your field work in dealing with contraceptive services were the only bases you relied on to reach the opinion that social and [129] economic disadvantage leads to difficulties for women traveling outside the region to access abortion care?

A. I was drawing on my experience—my 14 years experience as a sociologist, demographer, my knowledge of the literature, my teaching, yes.

Q. In your direct you give the opinion that demand exists for abortion services in El Paso and the Rio Grande Valley?

A. That is correct.

Q. You base that opinion on the number of pregnancies that end in abortion for women in these communities?

A. Yes.

Q. And that's in table 4 of the direct you submitted today; is that correct?

A. Yes. Table 4. I believe so.

Q. And your expert report also had a table 4 that corresponded with that?

A. Yes.

Q. At your deposition you told me that your version—the version of table four in your expert report had some errors in it?

A. Correct. I had inadvertently added the El Paso numbers to Rio Grande Valley numbers, which I corrected in my deposition.

Q. And you corrected that for your direct testimony; is that correct?

A. Correct.

[130] Q. I'm going to pull up your—this is table 4 from your direct testimony; is that correct?

A. Yes.

Q. And the line you said you fixed was the total RGV counties at the bottom; is that correct?

A. That is correct.

Q. Can you take a look and review that? Are there not still errors in your analysis? Specifically the abortion—abortions line?

A. Yes. The number is correct in the testimony. The number is 2,000 in the line of the testimony in the text. But you're right. The number is incorrect in the table here.

Q. So for total RGV counties for abortions, that should actually read 2,619?

A. Yes. That number is correct in the written testimony on—I don't have the testimony in front of me. But in that paragraph it is corrected.

Q. And the 2,619 are the numbers of abortions that were performed on women who reside in the Rio Grande Valley in 2011; isn't that right.

A. Yes. Residing in the Rio Grande Valley counties, yes.

Q. And I guess I should clarify that's women age 15 to 44?

A. Correct.

Q. And 69,439 abortions were performed on Texas residents in 2011?

[131] A. Yes. According to the Department of State Health—Department of State Health Services data from 2011, yes.

Q. And that's what you relied on in your report?

A. Correct.

Q. And that 2,619 number of abortions performed on Valley residents represents only 3.7 percent of the total abortions performed in Texas in the year 2011; is that correct?

A. Is that a question?

Q. That's a question. And I have calculator up there if you'd like to verify my math?

A. Could you tell me the number again?

Q. 2,619 out of 69,439 total abortions?

A. What was the number you said?

Q. 3.7 percent?

A. 3.77. I would round up to 3.8, yes.

Q. 3.8. Even fewer El Paso residents received abortions in 2011?

A. El Paso County?

Q. El Paso County.

A. Of the total in Texas? Yeah.

Q. 2,181 residents of El Paso received abortions in 2011; isn't that right?

A. 2,182, yes.

Q. And I did the math on that. That's about 3.1 percent of all total abortions in Texas were performed on residents of [132] El Paso?

A. Okay.

Q. Does that sound about right?

A. Sure. Yeah.

Q. So that means, in total, only about 6.9 percent of all abortions in 2011 were performed on women in these two communities?

A. 3.8.

Q. 6.9.

A. You said 3.8 and what was the

Q. 3.1.

A. 3.1? Yes.

Q. Demand in the Rio Grande Valley and El Paso County are lower than the rest of the State?

A. A smaller percentage of abortion—of pregnancies end in abortion in those two communities compared to the state average, yes.

Q. The state average is 15.5 percent.

A. That's correct.

Q. That includes numbers from the Rio Grande Valley and El Paso?

A. It does.

Q. If you would take those out, that number would be even higher?

A. Yes. I would imagine so. Uh-huh.

[133] Q. So El Paso has only—has a 13.5 percent abortion rate?

A. It's not an abortion rate. It's the percent of abortions—percent of total pregnancies that end in abortion.

Q. I apologize. 13.5 percent of pregnancies ended in abortion for Residents of El Paso County in 2011?

A. Yes.

Q. And 9.4 of pregnancies ended in abortion for residents of the Rio Grande Valley?

A. That's correct.

Q. And these numbers are taken in 2011?

A. Correct.

Q. And that was two years before House Bill 2 was passed?

A. Yes.

MR. SOTO: We'll pass the witness, Your Honor.

REDIRECT EXAMINATION

BY MS. BHANDARI:

Q. Dr. Hopkins, you were asked in your cross-examination about your opinion that levels of disadvantage might serve as a barrier to women accessing health care services; is that correct?

A. That is correct.

Q. Is this opinion a controversial one in the field of demography?

A. Not at all.

Q. Is this a controversial one in the field of sociology?

[134] A. No.

Q. You were asked about your inclusion of figures for the number of women that have received abortions including in El Paso County and the Rio Grande Valley; is that correct?

A. Yes.

Q. Why did you include these figures in your testimony?

A. The number of pregnancies that end in abortion?

Q. That's correct.

A. To demonstrate that women in these areas—that a large number of women in these two communities have—have ended—ended their pregnancies with abortion.

Q. And so when you say that there is a demand for abortion services, what do you mean by that?

A. That women desire—that some women desire to end their pregnancies who live in these communities.

Q. And the numbers that you found demonstrate that demand; is that correct?

A. That's correct. So for the total Rio Grande Valley, the 9.4 percent translates to one in every 11 pregnancies in 2011 ended in abortion.

Q. And you were asked on cross-examination about the percentage of—of the total number of abortions in Texas that are performed on women from these regions; is that correct?

A. I'm sorry. Would you repeat the question?

Q. Sure. On cross-examination you were asked about the [135] percentage of abortions in El Paso County and in the Rio Grande Valley as compared to the rest of the state; is that correct?

A. The percentage of pregnancies that end in abortion, correct.

Q. And can you think of reasons why those percentages might be lower than for the rest of the State of Texas?

A. Perhaps a wide variety of reasons. There's less access to abortion in the Rio Grande Valley. It may be harder for those women to even get to the—like Mr. Soto mentioned with the previous witness, that to travel the 60 miles from Brownsville to the McAllen clinic where it's a little closer, that even that may have been difficult to overcome those barriers.

Q. And does the exact percentage for both of those regions, for El Paso County and for the Rio

Grande Valley, affect your opinion that there is a demand for abortion services in those counties?

A. No. The percentage of abortion—pregnancies that end in abortion varies among these communities, but there's still demand. I mean, we see in these two communities there's over 4,000 women whose pregnancies ended in abortion.

MS. BHANDARI: Thank you. No further questions.

MR. SOTO: No questions, Your Honor.

THE COURT: All right. You may step down.

MS. TOTI: Forgive me, Your Honor. The plaintiffs would a like to call Dr. Elizabeth Raymond.

[136] (Witness sworn)

ELIZABETH RAYMOND,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. TOTI:

Q. Dr. Raymond, could you please state your full name for the record.

A. Elizabeth Raymond.

Q. Thank you. Dr. Raymond, did you submit a trial declaration in this case?

A. I did.

Q. And does that trial declaration represent a complete and accurate statement of the testimony you wish to offer on direct?

A. It does.

MS. TOTI: Your Honor, Plaintiffs would like to move the trial declaration of Elizabeth Raymond into evidence.

MS. DAHLBERG: No objection, Your Honor.

THE COURT: All right. The declaration entitled Direct Testimony of Elizabeth Gray Raymond, M.D., M.P.H. is admitted.

MS. TOTI: Thank you, Your Honor. We pass the witness.

MS. DAHLBERG: Shelley Dahlberg on behalf of the State defendants Your Honor.

[137] **CROSS–EXAMINATION**

BY MS. DAHLBERG:

Q. Dr. Raymond, I want to start by establishing some things, that you are not—you are not a demographer, are you?

A. No, I'm not.

Q. Okay. And you're not a sociologist, are you?

A. No.

Q. And you are not a statistician, are you?

A. No.

Q. And you did not speak to any individual women for purposes of your analysis and the testimony that you offered here today; is that correct?

A. That is correct.

Q. Thank you. And you did not conduct any statistical analysis yourself for purposes of your testimony, did you?

A. No.

Q. Okay. Did you independently verify any of the results of the various studies in your report or in your testimony that you relied on?

A. I contacted some of the authors to confirm that they were—they had done those studies and that the data in the papers that I reviewed were accurate.

Q. But you didn't do any—any statistical analysis or checks of the data in those reports to ensure that they were accurate?

[138] A. No.

Q. And your testimony here today is based on your knowledge of how abortion services are performed and any complications that occur; isn't that correct?

A. Yes.

Q. Okay. And I want to ask you a little bit about the study that you relied on. It's the UCSF Med-Cal Study by Bennett. Do you recall that?

A. Yes.

Q. In that study the researchers found a 2.1 percent complication rate, right?

A. I don't have the documentation in front of me, but that sounds about right.

Q. Okay. Would you be more comfortable if I gave you a copy of your direct testimony?

A. Sure.

Q. Okay. Did you find that there in the chart?

A. Yes.

Q. So 2.1 percent complication rate. Is that accurate?

A. Yes.

Q. Okay. And in that study those—the abortion services that were analyzed were provided through California's Medicaid program, right?

A. Right.

Q. And so it was limited only to those services?

[139] A. That's correct.

Q. And the study there did not take into account any other abortions that were provided in California, right?

A. That's correct.

Q. And so none for privately run facilities, right?

A. That's correct.

Q. None for those paid through health insurance or out of pocket by the patient?

A. Well, I want to just clarify. When you say by privately held facilities, they were paid for by the fee-for-service Medi-Cal in California.

Q. But if they weren't—if they weren't provided in fee-for-service through Medi-Cal, the study did not include that?

A. Yes.

Q. Okay. And it didn't include situations where the patient may have visited the ER but not received treatment, right?

A. Can you say that again?

Q. Well, the study didn't include situations where the patient may have visited the emergency room for some sort of complication arising out of abortions but didn't receive any treatment?

A. No. I don't think that is correct.

Q. You don't think that's correct?

A. Yes.

[140] Q. Okay. Well, the study presumes also that all of the causes of whatever the symptoms were reported accurately, correct?

A. Yes. That's correct.

Q. And the study's unpublished?

A. That's correct.

Q. And just so we understand the basis for your testimony, none of your opinions that you're offering here today are related to where—are related to whether or not admitting privileges are required?

A. Could you say that again?

Q. You know, I'm sorry. I'll withdraw that question.

Did you do a study that compared abortion safety in an ambulatory service center versus—provided in an ambulatory service center versus abortions that would be provided outside of an ambulatory surgical center?

A. No.

Q. Okay. And a study of that type certainly would have been feasible, correct?

A. Studies of that type would have been feasible?

Q. Feasible.

A. I suppose so.

Q. Okay. And you didn't rely on any such study for your analysis, correct?

A. That's correct.

[141] Q. Okay. And now I really want to just move on very briefly to your ultimate opinions. You would agree with me, wouldn't you, that there are at least some health care providers who believe that admitting privileges benefit the health and safety of women undergoing an abortion?

A. So I understand.

Q. And some of these benefits that these providers believe are offered by this requirement would include continuity of care, correct?

A. So I understand, correct.

Q. And maybe they would ensure the competency of the provider?

A. That's—yes.

Q. And because I know the Court doesn't love acronyms, can you please—please state for clarity in the record what the AAAASF is. I actually couldn't find that in your testimony.

A. Yeah. It's in there somewhere. I thought it was. It's the American Association for Accreditation of Ambulatory Surgery Facilities.

Q. Okay. Thank you. And those guidelines show that admitting privileges at a local hospital are one way to demonstrate clinical competence, correct?

A. My testimony isn't about whether those admitting privileges are a way to demonstrate clinical competence. My testimony was about whether this organization requires them in [142] its—in its standards.

Q. Well, and in that particular instance, they don't require them. But those standards acknowledge that it's one way to show clinical competence, right?

A. Well, I—the—the part of the standards that I'm citing here aren't really about clinical competence. They're about whether those—they're about the standards for accrediting these—accrediting facilities by that organization.

Q. If you'll turn—if you'll please look at page 13, and it's paragraph 3. It will—it's the second paragraph in paragraph—

A. I see where you are, yeah.

Q. Wouldn't you agree with me that the very first sentence in that states that admitting privileges is—you state in your testimony that admitting privileges are not the only way to demonstrate clinical competence?

A. Right.

Q. And so they may not be the only way, but they are a way to demonstrate?

A. Yes.

Q. Thank you. And you would also agree with me, wouldn't you, that there are at least some health care providers who believe requiring a clinic to be an ASC benefits the health and safety of a woman choosing to undergo an abortion?

[143] A. It's my understanding that's true, yes.

Q. And also some physicians believe that because during an abortion a woman's cervix and uterus, which are—are sterile, are penetrated during that procedure, that an abortion is considered an invasive—an invasive procedure, correct?

A. Yes.

Q. And just so the record is clear, you do disagree with those health care providers, right?

A. That I disagree with?

Q. You disagree with those health care providers?

A. Yes.

Q. I finally just want to quickly touch on your testimony about access to abortions. For purposes of your testimony and analysis, you are simply assuming that the ASC requirement will hamper women's access to abortion?

A. Yes.

Q. And that's the same with the admitting privilege requirement, correct?

A. Yes.

Q. It's an assumption that—okay.

And that assumption is that the number of clinics in Texas will decline?

A. Yes.

Q. And you don't know that that will happen for sure, do you?

A. No.

[144] MS. DAHLBERG: No further questions for this witness, Your Honor.

REDIRECT EXAMINATION

BY MS. TOTI:

Q. Thank you, Dr. Raymond. You currently serve as a senior medical associate at Gynuity Health Projects; is that correct?

A. Yes.

Q. Can you tell us what kind of work you do there?

A. Well, I do lots of different kinds of work—I design studies, I manage them, I analyze the data, write out the data for publication. I also do other kinds of—other kinds of non-research work. I evaluate

the possibility of developing new approaches to reproductive health care. I work on guidelines for providing health care, educating providers about the scientific basis for health care.

Q. Is evaluating the methodology of research studies an important part of the work that you do?

A. A very important part.

Q. And over the course of your career, how much experience do you have doing that work?

A. Decades. About 25 years or so, I would say.

Q. So, Dr. Raymond, you—you were asked some questions about a study out of the University of California at San Francisco. Do you recall that?

A. Yes.

[145] Q. I believe that that study is referenced beginning on page 5 of your direct testimony?

A. Yes.

Q. I would like to ask you a couple of questions about it.

Do you have any reason to think that Medi-Cal patients experience lower rates of abortion-related complications than other patients who have abortions?

A. I have no reason to think that, no.

Q. You testified that this study hasn't been published. Do you expect it to be published?

A. I do.

Q. To date, has it gone through any form of peer review?

A. Yes. It's been presented at conferences, and those—to be accepted for presentation, there is a form of peer review.

Q. Can you talk a little bit about the methodology of this study?

A. Well, the—the researchers collected or obtained the data from the Medi-Cal program about all of the abortions, which totaled over 54,000 abortions in 2009 and 2010. They also obtained data about all of the medical care that those patients had received within the six weeks after the abortion that was paid for by Medi-Cal.

And they reviewed these data. They had a clinical—a team of clinicians who reviewed all of these data—a huge job—so they could look to see what kinds of medical events [146] occurred after each—after these 54,000 abortions.

Q. Do you have confidence in the reliability of the findings of this study?

A. I think it's a very good study.

Q. Why?

A. Well, first of all, it's very large. It's population-based. It has—it includes abortions performed at many different facilities over several years. And it—because it includes the data, the medical information from all of these patients from all of their visits to any provider that was paid by Medi-Cal, it has essentially complete follow-up—complete medical follow-up for these patients. And that's quite—that makes it very valuable.

Q. I'd also like to ask you about the other studies identified in the table on page 8 of your direct testimony.

A. Yes.

Q. Do you have confidence in the findings of the other studies identified in the table?

A. I do.

Q. And why is that?

A. Well, because they were—I reviewed the methodology of all of those studies as well, and they—it seems very sound to me. They—this was a—you know, a number of different studies, as you can see here, conducted in different patient populations by different researchers in different places. And [147] the result of these studies are all consistent, and that's a—that's an important—that's an important consideration in evaluating data, that lots of different kinds of data from different sources leads to the same conclusion. That increases competence.

Q. So I believe you testified concerning the UCSF study that follow-up was essentially complete in that study; is that right?

A. Yes.

Q. What about in these other studies? Was there complete follow-up?

A. No. Well, not—some of them don't—didn't report a follow-up rate. They weren't really designed with a follow-up rate in the typical sense. Others did have a report of a follow-up rate. They had planned a follow-up date, and it was not completed in those studies. That's why the UCSF study is so valuable.

Q. And yet I believed you testified that the results of all the different studies, including the UCSF study, were comparable; is that right?

A. Yes. They all lead to the same conclusion, which is that abortion is very safe. It has a low complication rate.

Q. So what, if anything, does that tell you about the studies that didn't have complete follow-up?

A. Well, it gives me confidence that probably most of, if not [148] all of, the complications were ascertained in those studies. I think one thing to consider here is that even if there was some under-ascertainment—even if you—if we assumed that there were more somewhat more complications than were reported, the rates would—the complication rates would still be very low.

Q. Okay. And I believe Ms. Dahlberg asked you some questions about the basis for your opinions about abortion-related complications and mortality. In paragraph 13 of your direct testimony, you talk about data collection by the CDC—by the U.S. Centers for Disease Control and Prevention; is that correct?

A. Yes.

Q. And what is the methodology used by the CDC to collect data about abortion-related deaths?

A. Well, they use—they obtain data from a variety of different sources, including state vital records, media reports, reports by citizens, providers organizations, hospitals. They—they really do quite a masterful job, I would say, in trying to find all of the reports—known abortion deaths in the country.

Then they review—they obtain—about each death that they become aware of, they attempt to find additional records. And they have clinicians reviewing those records to determine whether or not the death was abortion related.

Q. So would it be fair to say that—that in collecting data [149] about abortion-related mortality, the CDC isn't relied solely on data reported to it by state vital statistics agencies?

A. That would be correct, yes.

Q. So, Dr. Raymond, also in your direct testimony I believe you mentioned an article that you co-authored

comparing the safety—or, rather, the mortality rate associated with legal induced abortion to the mortality rate for other pregnancy outcomes; is that correct?

A. Yes.

Q. Can you tell us a bit about that study and what it found?

A. Yes. I—I published that study with a colleague in 2012, and our objective was to compare the mortality associated with abortion in this country to the mortality associated with childbirth.

And so what we did was to—we used national statistics about abortion-related deaths and the number of abortions to determine the abortion-related mortality rate. And then we also used information about the —about deaths among women who had live births. Also national—national numbers. And the—we learned that the risk of death associated with childbirth, delivery of a live baby, was about 14 times the risk of death associated with abortion.

Q. So, in fact, some of the opinions that you're offering here today are in fact based on your own statistical analysis. Is that fair?

[150] A. Yeah. I wouldn't call it statistical. That's just sort of arithmetic.

Q. Got it. Forgive me. I'm not a scientist. I don't necessarily appreciate those fine statistics.

So are the finds of your study comparing mortality from legal induced abortions to mortality of other

pregnancy related outcomes, are those findings reliable?

A. Are they what?

MS. DAHLBERG: Objection, Your Honor. Foundation.

THE COURT: Why don't you restate your question. And Ms. Dahlberg is correct. You need to lay a foundation for this opinion.

Q. (BY MS. TOTI) Sure. So, Dr. Raymond, I believe a few moments ago you testified about the findings of this study that you published comparing mortality from abortion to mortality from childbirth; is that right?

A. Yes.

Q. Are those findings reliable?

A. I believe so.

Q. What gives you confidence in the reliability of those findings?

A. Well, the sources of the data I think are reliable, and that's—the paper was published in a peer-reviewed journal, which suggests that the reviewers in the journal and the editors also thought they were reliable.

[151] Q. On the next page, on page 10 of your direct testimony, you provide a table comparing data

about maternal deaths in Texas and deaths from abortion in Texas; is that correct?

A. You mean page 8?

Q. I—

A. This one it's—anyway, I see the table. Table 2.

Q. I'm looking at table 2.

A. Yes.

Q. And what is the source of this data?

A. I obtained it from the Texas Department of State Health Services Web site.

Q. And focusing on just the most recent five years worth of data, would that be 2008 to 2012?

A. Yes.

Q. Is 2012 the most recent year for which data are available from the Department of State Health Services?

A. Yes.

Q. Have you done a calculation of the overall maternal mortality ratio for the years 2008 to 2012 using this Texas data?

A. Yes.

Q. And approximately what is the overall maternal mortality ratio in Texas for that time period?

A. It was about 27 deaths per 100,000 life births.

Q. And have you done a calculation of the rate of abortion [152] deaths in Texas using this data during this same time period?

A. Yes.

Q. And what is that figure?

A. It was about .27 deaths per 100,000 abortions.

Q. So what is the relationship between those two numbers?

A. One is 100 times the other.

Q. Which one is 100 times the other?

A. The maternal mortality ratio is 100 times the abortion-related death rate.

Q. So what does that tell you about the risk of continuing a pregnancy in Texas versus the risk of having an abortion?

A. There are many, many more deaths among women who choose to continue their pregnancy than among women who choose to have an abortion.

Q. Dr. Raymond, Ms. Dahlberg asked you some questions about what some physicians might believe. Do you recall those questions?

A. Yes, I do.

Q. So the opinions that you are offering in your testimony, what are they based on?

A. They are based on the data that I reviewed and the years of experience that I have working in this field.

Q. In your view is data a matter of opinion?

A. No.

Q. Dr. Raymond, are you familiar with a publication called [153] *TeLinde's Operative Gynecology*?

A. I am.

Q. What do you know about that publication?

A. It's a textbook of gynecologic surgery that's used in medical schools and residencies. It's a reference book. It's in fact the leading reference book on that—on that topic.

Q. You attended medical school, correct?

A. Yes.

Q. And you are in fact an obstetrician/gynecologist?

A. Yes.

Q. Did you use this textbook?

A. Yes, I did.

Q. And it remains the standard in the field today?

A. Yes.

Q. Is it specifically geared towards abortion providers?

A. No.

Q. Who is it geared towards?

A. It covers all gynecological surgery.

Q. So in your direct testimony, you offered some opinions about colonoscopy, correct?

A. Yes.

Q. And I believe that you compared mortality and morbidity from colonoscopy to mortality and morbidity from legal induced abortion; is that right?

A. I did.

[154] Q. Do you think that's a fair comparison?

A. Let me explain the reason why I made that comparison. The—I testified that the abortion-related mortality rate is about—in the past decade or so was about .69 deaths per 100,000 abortions. And I think that it's—that kind of number is difficult for people to understand just on an absolute basis. Is that a high number? Is that a low number?

So one way we have of understanding numbers like that is by comparing them to other numbers that we find satisfactory, other numbers from comparable—that we might look at in comparable situations. So colonoscopy is like abortion, in that it is an outpatient procedure, it's very common, it's—a colonoscopy, in fact, is recommended for both for screening and diagnosis, it's performed in outpatient facilities.

And it's useful, I think, to understand or to know or to be able to contrast or compare the complication rate of that procedure, which we sort of accept, to the complication rate of abortion as both are currently practiced. So, yes, I think it's a fair comparison.

Q. Thank you. And on page 19—we might have different page numbers for some reason. In paragraph 48 of your direct testimony, do you offer an opinion about whether surgical abortion satisfies a particular definition of invasive procedure; is that right?

[155] A. Paragraph what?

Q. Forty-eight?

A. Oh, 48. Hold on. Yes.

Q. And in this paragraph I believe you indicate that a woman's vagina is an orifice that is normally colonized with bacteria; is that right?

A. That's right.

Q. Is that a matter of opinion?

A. No. It's a matter of fact.

Q. Is that an issue on which reasonable physicians might disagree?

A. No.

MS. TOTI: I have no further questions, Your Honor.

THE COURT: Recross?

MS. DAHLBERG: Yes, Your Honor. Just a couple of very short questions.

RECROSS–EXAMINATION

BY MS. DAHLBERG:

Q. Dr. Raymond, I'd like to go back to this US—UCSF study. Was Dr. Daniel Grossman a coauthor of that study?

A. Well, the study hasn't actually been published yet, so

Q. Did he contribute to the unpublished study?

A. I believe so, yes.

Q. And you don't have any reason to dispute that in that study it found that 6.4 percent of the patients who are [156] analyzed at having an abortion went to the emergency room within six weeks of that procedure; is that correct?

A. 6.4 percent of the abortions were followed by an emergency room visit? Yes. That's right.

Q. Okay.

MS. DAHLBERG: I have no further questions,

Your Honor?

THE COURT: Ms. Toti, anything further?

MS. TOTI: Just very briefly, Your Honor.

FURTHER DIRECT EXAMINATION

BY MS. TOTI:

Q. Dr. Raymond, does the fact that a patient visits the emergency room tell you anything about whether that patient has experienced an abortion-related complication?

A. No. One would want to know why they visited the emergency room. A patient might visit an emergency room after having an abortion for any number of reasons that have nothing to do with the abortion.

Q. In your experience, does every patient who visits the emergency room get admitted to the hospital?

A. No. Very—no. Not at all.

MS. TOTI: Nothing further, Your Honor.

THE COURT: Ms. Dahlberg

* * *

[157] **FURTHER CROSS-EXAMINATION**

BY MS. DAHLBERG:

Q. Dr. Raymond, your testimony was that 6.4 percent of visits to the ER didn't tell you anything about why they went; is that correct?

A. Not that one number, no.

Q. Okay. And so if this—this UCSF study found that, of the 6.4 percent that went to the emergency room, 40–40.2 percent of those visits to the emergency room were related to the abortion procedure, you wouldn't have any reason to dispute that finding in the study, would you?

A. I don't remember the exact number. In this study they—so 6.4 percent of abortions were followed by a visit to the emergency room, but most of those were for reasons that were not related to the abortion. And even most of those that were related to the abortion were not—did not result in any treatment.

So some people go to an emergency room after an abortion because they are worried about something. But it turns out that what they were worried about really wasn't medically—clinically significant or certainly not enough to need any treatment. They are reassured and sent home. And that's apparently what the case was with a lot of these—most of these visits.

Q. But, again, 40 percent of the visits to the emergency room [158] were abortion related?

A. I don't remember the exact number. Most of them were not. So

Q. And the study in the record speaks for itself, doesn't it?

A. Pardon?

Q. And if the study is in the record and before the Court, it will speak for itself, won't it?

A. That's correct. Yes.

Q. Thank you.

MS. DAHLBERG: Nothing further.

THE COURT: Ms. Toti?

MS. TOTI: Nothing further, Your Honor.

THE COURT: All right. You may step down.

MS. TOTI: Your Honor, the plaintiffs call Dr. Sherwood C. Lynn.

(Witness sworn)

SHERWOOD C. LYNN, JR.,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. TOTI:

Q. Good afternoon, Dr. Lynn?

A. Good afternoon.

Q. Could you state your full name for the record?

A. Sherwood C. Lynn, Jr.

Q. Dr. Lynn, have you submitted a written declaration of your [159] trial testimony in this case?

A. Yes.

Q. And does that trial declaration represent a complete and accurate statement of the testimony that you wish to offer in this case?

A. Yes.

MS. TOTI: Okay. Your Honor, I'd like to offer into evidence the trial declaration of Dr. Lynn.

MR. SOTO: Your Honor, we have objections to specific portions of the testimony. This witness is also out of order. We do request a short break prior to continuing cross-examination because the witness is out of order on the witness list.

THE COURT: Okay. But I don't understand why you need a short break just because the witness is out of order.

MR. SOTO: I'm sorry we just weren't—this just deviated from the witness order that—

THE COURT: Well, we have—according to my list, we've had some deviations. We started with witness number two, we went to witness number five, we came back to witness number three. We went to—so I don't—I don't understand.

MR. SOTO: I'm sorry we agreed on a witness order prior to the start of trial, and we weren't expecting this witness in this specific order.

THE COURT: So I'm the only one that didn't know [160] about the witness order.

MS. TOTI: Apologies for that, Your Honor. We—the proceedings have moved a little faster than we expected today. We had sent notice to the Court of the first four witnesses. But, you know, we got through those witnesses very quickly, and we've been trying to heed Your Honor's admonition about having no gaps in the testimony, so we've been trying to get additional witnesses here and on the stand as expeditiously as possible.

THE COURT: We may have another problem while we're discussing this. You have provided me with a book called Plaintiffs' Direct Testimony which heretofore had all of the declarations in it in order that I could review those as we went along. I do not have a declaration from Dr. Lynn, although I do have a tab in that book for him. Is his report found?

MS. TOTI: Your Honor, I can hand that up to you if you'd like. Would you like me to hand you up a copy of Dr. Lynn's testimony? I apologize for that.

THE COURT: That's fine. Please pass it up. Now, Mr. Soto, you're going to have to give me a better reason why you're unprepared.

MR. SOTO: We can go forward, Your Honor. That's fine.

THE COURT: All right. Then go forward, we will.

[161] All right. There has been offered the declaration entitled Direct Testimony of Sherwood C. Lynn, Jr., M.D. Do the defendants have objection to that document?

MR. SOTO: We have objections to portions of that document—paragraph 9, paragraph 10, and paragraph 14—for hearsay objections.

THE COURT: Well, Ms. Toti, what is your response to that?

MS. TOTI: Your Honor, paragraph 9 is based on the witness's personal knowledge. All of—all the information contained in these paragraphs are based on the witness's personal knowledge and correspondence that was received by the witness. I mean, these are—the witness applied for admitting privileges, received a letter from the hospital denying his request for admitting privileges application, and relied on that letter in forming the belief that, in fact,

he doesn't have—he's not eligible to apply for admitting privileges at those hospitals. The witness will be able to authenticate the letters that are addressed to him. One letter was sent by him. One was received back from the hospital.

THE COURT: Mr. Soto?

MR. SOTO: Your Honor, particularly for paragraph—I'm sorry—for paragraph 11, this is the main source of our objection. In this it's essentially double hearsay based on an anonymous doctor. He says that other physicians expressed [162] concern about retaliation from the hospitals and expressed concerns of people at Whole Woman's Health that then relayed to him. That's double hearsay, and the source of that original—the original source of that is also anonymous. So we object on hearsay grounds particular for paragraph 11. And to the others for—to the extent that they're offered for the truth of the matter asserted.

THE COURT: Well, here's what I'm going to do. I'm going to take those objections under advisement, but we'll allow you when you cross-examine the witness to test those paragraphs—we can call it voir dire or not, but you're going to have him in just a moment—and then I will rule on the individual objections after we determine whether or not he can lay a predicate to make those statements that would constitute an exception to the hearsay rule.

MR. SOTO: Thank you, Your Honor.

THE COURT: So with that ruling having been made, the declaration entitled Direct Testimony of Sherwood C. Lynn, Jr., M.D. is admitted, subject to the Court's later ruling on the objections made by the State.

MS. TOTI: Thank you, Your Honor.

THE COURT: Now, Mr. Soto, you may so test.

MR. SOTO: Thank you, Your Honor.

* *

CROSS-EXAMINATION

BY MR. SOTO:

Q. Good afternoon, Dr. Lynn.

A. Good afternoon.

Q. You're currently a physician employed by Whole Woman's Health?

A. Yes.

Q. And where are you employed?

A. I'm sorry.

Q. Where do you work specifically?

A. At present in San Antonio.

Q. And you also work for their—you also worked for their clinic in Austin when it was opened; is that correct?

A. Austin and Beaumont and McAllen.

Q. You worked for the clinic in McAllen?

A. I'm sorry.

Q. You worked for their clinic in McAllen?

A. Yes.

Q. You have admitting privileges in San Antonio and Austin?

A. Correct.

Q. You applied for admitting privileges in the last year at seven different hospitals in the Rio Grande Valley?

A. Can I clarify? Before one applies, one gets a pre-application application. And we never got—we got, I think it was, one pre-application, and none of the hospitals [163] sent applications.

Q. And that's because you couldn't get a sponsoring physician from that hospital to sign off on your application? I'm sorry. Let me rephrase.

In order to get an application for those seven hospitals within 30 miles of McAllen, a physician at one of those hospitals had to sponsor you?

A. Correct. Or act as backup.

Q. And the purpose of that is, if you're not available, that that sponsoring physician would step in for you?

A. I can't answer that. I'm not sure why hospitals—those hospitals require that.

Q. When you were applying for privileges in McAllen, your plan wasn't to move to McAllen, was it?

A. No.

Q. To permanently relocate?

A. No.

Q. And what did you personally do to find physicians to sponsor you in McAllen?

A. I called a number of them.

Q. Who did you call?

A. I am not sure—I'd rather not say. I'm uncomfortable with that.

MR. SOTO: Your Honor, we'd ask for an instruction to answer.

[164] MS. TOTI: Your Honor, we object to identifying the names of particular physicians on the record.

THE COURT: Well, it does go to the weight of his testimony and the credibility of the witness in determining the attempts he has made to obtain admission—admitting privileges by virtue of his attempting to get local references for it.

At this point I'm not prepared to order him to disclose the names, but I would like numbers of people he contacted that are more definite than what he has stated and at least some indication as to the field of medicine in which the people he contacted practiced in order that I can make an evaluation of his testimony.

We'll attempt to do this without using specific names, but his testimony is not going to have very much weight with the Court if he can't at least get closer using some type of procedure such as I outlined.

MS. TOTI: I understand, Your Honor. Thank you.

THE COURT: You may proceed, Mr. Soto.

Q. (BY MR. SOTO) How many physicians did you contact in McAllen?

A. I called a number, and three specifically said they would not because they were afraid of retribution.

Q. What areas are these—

A. All of them are OB/GYN.

[166] Q. What hospitals—in order to get—the sponsoring physician has to have privileges at the hospital you're applying to, correct?

A. Right.

Q. Which hospitals did these three physicians who told you, no, which hospitals did they have privileges at?

A. I think they all had privileges at Renaissance.

Q. Is that the only hospital they had privileges at?

A. I'm not aware of the others.

Q. And other than these three physicians, did you—did you meet with them in person?

A. No.

Q. How long was your phone call with them?

A. Moments.

Q. Moments.

A. It was almost immediate rejection. No. They wouldn't do it.

Q. Did you travel to McAllen to have any meetings with any physicians?

A. I went down a couple of times, and we met on the phone. One of the guys was—was out of town, but we talked on the phone.

Q. You didn't meet in person with any of these physicians?

A. One.

Q. One.

[167] A. The one who—whose name was on the pre-application form.

Q. He's the one who actually—he's the one who sponsored you for your application at Renaissance?

A. Correct.

Q. For the other six hospitals, did you meet with any physicians who had admitting privileges at those six hospitals?

A. No. I'm not aware of that, no.

Q. Other than hospitals within 30 miles of McAllen, did you apply for any privileges anywhere else in the Rio Grande Valley?

A. No.

Q. You didn't apply for privileges at Brownsville-area hospitals?

A. No.

Q. At Harlingen-area hospitals?

A. No.

Q. Raymondville-area hospitals?

A. Well, no. I don't know where Raymondville is.

Q. It's small.

A. Is there a hospital?

Q. Did you investigate that?

A. In Raymondville? No.

Q. So you have no basis for saying that hospitals in these areas would or would not accept an abortion provider—would accept privileges from an abortion provider?

[168] A. Excuse me?

Q. You have no basis in your experience to say that hospitals outside of 30 miles of McAllen, but still within the Rio Grande Valley, would either approve or not approve an applicant for admitting privileges?

A. Outside the Rio Grande Valley?

Q. Within the Rio Grande Valley, outside of 30 miles of McAllen.

A. No.

MR. SOTO: Pass the witness, Your Honor.

THE COURT: Ms. Toti?

REDIRECT EXAMINATION

BY MS. TOTI:

Q. Dr. Lynn, I've asked you to take a look at a couple of documents. One of them has been marked as Plaintiffs' Exhibit 68. Do you see that one?

A. Yes. 68.

Q. Pardon me one second.

THE COURT: Which number did you say, Ms. Toti?

MS. TOTI: Actually, I want to strike that, Your Honor. I would like to ask the witness to look at Plaintiffs' 69 first.

THE COURT: Sixty-nine?

MS. TOTI: Yes.

Q. (BY MS. TOTI) Dr. Lynn, are you familiar with this [169] document?

A. Yes.

Q. What is this document?

A. It's an application for—it's a letter requesting an application for privileges at Renaissance Hospital.

Q. And is—when you say Renaissance Hospital, do you mean Doctors Hospital at Renaissance?

A. Yes. Sorry.

Q. That's okay. To the best of your knowledge, is this hospital located within 30 miles of the Whole Woman's Health facility in McAllen?

A. Yes, it is.

Q. And what was the purpose of sending this letter?

A. To—to request an application for privileges.

Q. And why were you seeking an application for privileges at this hospital?

A. I can't remember the number of the law, but the legislature mandated hospital privileges within 30 miles of any clinic where abortions are performed by the person doing abortions.

Q. And is that your signature at the bottom of the letter?

A. Yes, it is.

MS. TOTI: Your Honor, Plaintiffs would move that Exhibit Number 69 be admitted into evidence.

MR. SOTO: No objection, Your Honor.

[170] THE COURT: Plaintiffs' Exhibit Number 69 is admitted.

Q. (BY MS. TOTI) Okay. Now, Doctor, I'd like you to take a look at Plaintiffs' Exhibit 68.

A. Okay.

Q. And this appears to be a collection of four letters; is that correct?

A. Correct.

Q. Doctor, does this exhibit appear to be a collection of four letters?

A. Yes, it is.

Q. I'll try to speak into the microphone.

Are any of those letters addressed to you?

A. Yes.

Q. Do you recall receiving that letter?

A. I do.

Q. Who sent that letter?

A. Marissa Castaneda.

Q. And who is she?

A. The CEO of Doctors Hospital at Renaissance.

Q. Do you understand that letter in Exhibit 68 to be a response to the letter that you sent Marked as Exhibit 69?

A. Yes, it is.

Q. What is your understanding of the reason that exhibit—the letter marked as Exhibit Number 68 was sent to you?

[171] A. The address from which the—my application letter was sent is an abortion facility.

Q. So is—is that your understanding of—let me go back and ask another question.

Do you understand this letter to be a response from Doctors Hospital at Renaissance to your request for an application for admitting privileges?

A. Yes.

Q. And based on this letter, did you have an understanding of the hospital's decision about your request for an application for admitting privileges?

A. Yes.

Q. And what was your understanding about that?

MR. SOTO: Objection. This calls for speculation.

THE COURT: No, it doesn't. Overruled.

MS. TOTI: Thank you, Your Honor.

A. The—if I may, it says in the letter that the decision is not based—

MR. SOTO: Objection. Hearsay, Your Honor.

THE COURT: Mr. Soto, do you really.

THE WITNESS: This paragraph—

THE COURT: Pardon me, Doctor. I'm talking.

Do you really take the position that these letters don't have any authentication value at all and that they are somehow not what they purport to be, which is a rejection of [172] Dr. Lynn's application at Doctors Renaissance Hospital?

MR. SOTO: We believe they're authentic, Your Honor.

THE COURT: I'm going to overrule your objection.

Now, I have a question for Dr. Lynn. And that is: Dr. Lynn, Plaintiffs' Exhibit Number 68 appears to the Court to be four letters from Doctors Hospital at Renaissance dated November 4th and December 2nd—three of them dated November 4th, one December 2nd of 2013. Three of those letters have the name of the person to whom they're directed apparently overlaid, because what I have are copies, with the words "redacted." Is it your testimony before this court that you received the originals of all four of those letters from Doctors Hospital at Renaissance?

THE WITNESS: No. I received only the one addressed to me.

MS. TOTI: Your Honor, Plaintiffs—Plaintiffs can withdraw Exhibit 68 and replace it with Exhibit 58, which is a copy of the letter addressed to Dr. Lynn that was produce by the hospital in response to a subpoena.

THE COURT: Well, I don't really understand what you're doing. Plaintiffs' 58 does not appear to replace 68. 58 appears to be a copy of Exhibit 69, not 68.

MS. TOTI: I apologize, Your Honor, if I've got the numbers wrong. I don't have the exhibits in front of me.

THE COURT: Well, while you're looking at them, based [173] on the statements that Dr. Lynn

made in response to the questions that I asked relative to what was Exhibit 68, I sustain the State's objection to the three letters where the name is marked out and indicated "redacted" because he is unable to identify those letters.

I continue to overrule the objection to the November 4th, 2013 letter that is addressed to him, but I am uncertain as to whether you have offered that one letter.

MS. TOTI: Okay. Your Honor, do you mind if I read the Bates numbers into the record so we can be clear?

THE COURT: You may go ahead.

MS. TOTI: So with respect to Plaintiffs' Exhibit 68, Plaintiffs would like to offer into evidence the page of the document that is Bates Numbered P 00003469.

THE COURT: Mr. Soto, do you have objection to that exhibit?

MR. SOTO: No objection to that exhibit, Your Honor.

THE COURT: All right. Admitted as Plaintiffs' Exhibit Number 68 is the letter dated November 4th, 2013 from Marissa Castaneda to Sherwood C. Lynn, Jr., M.D., bates stamped P 00003469.

Now, what you will need to do at a recess at some point, Ms. Toti, is to get a one-page example of what I've just admitted, show it to Mr. Soto, have it

Marked as Exhibit Number 68, and that will be part of the record.

[174] MS. TOTI: Your Honor, we may try to seek admission of the other letters through a different witness.

THE COURT: Well, why don't you mark them separately, or this record is not going to make any sense at all when it gets to the next court.

MS. TOTI: We will do that, Your Honor.

THE COURT: So why don't you do Plaintiffs' Number 68 as this letter that he has identified. And if you come back to the others, present them as additional exhibits.

MS. TOTI: I will do that, Your Honor. Thank you.

Q. (BY MS. TOTI) Doctor Lynn, can I just ask you, with respect to the November 4th letter addressed to you—I think I've taken your copy again—I'm just going to read a bit from this letter and ask you to tell me if I'm reading it correctly.

It says, "Dear Dr. Lynn, the Medical Executive Committee at Doctors Hospital at Renaissance met and reviewed your request for the release of application for privileges for you and your group. The Medical Executive Committee upheld the recommendation of the Credentials Committee to deny your request for application for membership and privileges."

Did I read that first paragraph correctly?

A. Yes.

Q. And then the second paragraph says, "The recommendation was forwarded to the Board of Governors for review, and a determination was made not to extend an application to you. [175] Such determination is as authorized under the bylaws and rules and regulations of the medical staff for the hospital. The decision of the governing body was not based on clinical competence consideration." Did I read that correctly?

A. Yes.

Q. And is the word "not" in that last sentence bolded?

A. It is.

Q. And then the final paragraph says, "Based on the foregoing, applications will not be forthcoming at this time. Thank you for your interest in our hospital."

Did I read that correctly?

A. Yes.

MS. TOTI: Thank you, Dr. Lynn. I have no further questions.

THE COURT: Redirect—or recross rather?

MR. SOTO: No questions, Your Honor.

THE COURT: All right. You may step down. At this time we will take our afternoon recess, and we'll be in recess until about 3:45.

(Recess)

(Open Court)

THE COURT: We have enough plaintiffs' lawyers to get started, so we will.

MR. BLACKLOCK: Your Honor, we have a housekeeping matter to discuss with you.

[176] THE COURT: All right.

MR. BLACKLOCK: The trial is moving along more quickly than we anticipated due to—there are two more witnesses, I believe, after this next witnesses that the plaintiffs intend to call. That's obviously not going to take up all of tomorrow or even most of tomorrow. The defendants' experts who are, you know, professionals with busy schedules have availability restrictions. They're available Wednesday and Thursday, which were the days that we anticipated putting on the case based on the schedule.

One way out of his conundrum that might make some good use of everyone's time that I've discussed briefly with the plaintiffs is just taking tomorrow off, having the plaintiff's put on their remaining couple of witnesses Wednesday morning, and then giving us a day and a half or so with our witnesses and they'll all be available.

THE COURT: Well, you've got a different problem, and that is that I now have a problem Wednesday morning. So I was—I just kind of—I did some E-mailing just now, and I was planning on us not working Wednesday morning anyway but I have bought some time out of Friday. But it doesn't appear that we need all of the time we were trying to buy anyway.

Where does that leave you if we don't work Wednesday morning? Where are we right now on where you think we are moving along? I will be honest with you. I never saw how this [177] could take four days, but I was willing to try to give it to you. I wasn't willing to give you the five because I never thought it could take five days to go through this.

But that having been said, we're into the trial. Things always look different once you get into the trial. It's just the nature of the beast. So where are we in talking about a schedule if we're not going to work Wednesday morning? What does that do to your witnesses, and how—where does it leave you, Mr. Lawrence.

MR. LAWRENCE: Your Honor, I think maybe one solution is we could put on the rest of our case tomorrow morning. There is—so we have two more witnesses who will appear tomorrow morning. We could finish up. And then whatever is going on on Wednesday morning could go on, and you could begin your case after that.

MR. BLACKLOCK: So we have Wednesday afternoon and all of Thursday. So we've got Tuesday afternoon off, Wednesday morning off, and then the defendants' case? I think we could do that. Don't you guys?

THE COURT: All right. So what do you want—go ahead, Mr. Lawrence.

MR. LAWRENCE: There was one issue of one witness—we're hoping to work out a stipulation, but it may not be possible—that we had to subpoena. That's Mr. Robinson, who is actually a defendant in this case. So that's the one [178] witness we would have to take sometime during your case, I presume, if we can't work that out.

MR. BLACKLOCK: Yeah. We'll work with you on that. If you can—if she's here to testify, we wouldn't object to you putting her on during our case.

MR. LAWRENCE: If she's not here to testify, we may have to subpoena her to be here to testify.

THE COURT: What, then, do you propose doing for the rest of the afternoon today?

MR. LAWRENCE: Your Honor, I think today we maybe will put on one more witness, who is Ms. Anne Layne-Farrar. And, Ms. Toti, is there anything else we should try to resolve today?

That may be sufficient, Your Honor. We could—we could do two more witnesses in the morning.

THE COURT: Have we finished with Dr. Lynn?

MR. LAWRENCE: We have, Your Honor.

THE COURT: All right. And are you finished with Dr. Lynn?

MR. SOTO: Yes, Your Honor.

THE COURT: All right. Because my notes didn't reflect whether both sides had passed him finally.

All right. Then here's what we will do, let me get to the right script here. We will proceed as you have suggested this afternoon. We will proceed in the morning with [179] the two witnesses that the plaintiff has. Then we will recess until 1:30 on Wednesday and go Wednesday afternoon, and the anticipation is we would finish up Thursday; is that correct?

MR. BLACKLOCK: That's correct, Your Honor.

THE COURT: Mr. Lawrence, do you agree?

MR. LAWRENCE: That works perfectly for us.

THE COURT: Then that's what we will do. So I will not invoke my Judge Roberts story and tell you to go ahead and argue today.

MR. BLACKLOCK: Thank you very much for your flexibility.

MS. DAHLBERG: I would just like to say that the lawyers were very nervous about you invoking your Judge Roberts rule. I counseled them to be honest with the Court about the difficulty. So thank you.

THE COURT: You have proved your worth at counsel table.

MS. DAHLBERG: I earned my pay today.

THE COURT: All right. Well, we will proceed that way then.

MR. LAWRENCE: Okay. Thank you, Your Honor.

THE COURT: So Mr. Lawrence?

MR. LAWRENCE: Your Honor, the plaintiffs call Anne Layne-Farrar.

THE COURT: All right.

[180] (Witness sworn)

ANNE LAYNE-FARRAR,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. LAWRENCE:

Q. Ms. Farrar, could you please state your name for the record.

A. Anne Layne-Farrar.

Q. Ms. Farrar, did you submit direct testimony in this case?

A. I did.

Q. And you submitted that in written form?

A. Yes.

Q. And is it a true and accurate and complete statement of your testimony in this case?

A. Yes.

MR. LAWRENCE: Your Honor, the plaintiffs would like to move into evidence the direct testimony of Ms. Anne Layne-Farrar.

MS. DAHLBERG: No objection, Your Honor.

THE COURT: All right. The Court admits into evidence the declaration entitled the Direct Testimony of Anne Layne-Farrar, Ph.D.

MR. LAWRENCE: With that, Your Honor, I pass the witness.

MS. DAHLBERG: Sally Dahlberg for the State [181] defendants.

CROSS-EXAMINATION

BY MS. DAHLBERG:

Q. Dr. Layne-Farrar, I just want to start with you and talk about some of the qualifications. You're not a physician, right?

A. That's correct.

Q. And you don't have any medical training?

A. That's right.

Q. And you don't have any formal scientific training?

A. That's right. Medical scientific training. I consider economics scientific.

Q. Thank you for that clarification.

You're not an architect?

A. No, I'm not.

Q. And you don't have any expertise or training in building, like construction codes?

A. No, I don't.

Q. And in your regular business practice, you have not studied the economics of the medical side of health care; isn't that correct.

A. I've not studied—I'm sorry?

Q. The economics of the medical side of health care?

A. That's correct.

Q. Okay. And you don't have any publications related to [182] health care law or abortion—the provision of abortion services?

A. That's correct.

Q. And you would agree with me, wouldn't you, that evaluating and valuing life in a cost benefit analysis is subjective?

A. Evaluating the—let me restate that.

Q. Valuing life.

A. Valuing life? You can—economists frequently do value portions of a law. For example, lost earnings, those kinds of things. But placing a dollar value on life itself, no. That's highly subjective.

Q. Thank you. And of the cost benefit analyses that you've done in your regular course of business up to this point, none of those have been related to the provision of abortion services, correct?

A. That's right.

Q. And so these are the first ones that you've done was for this case?

A. First cost benefit analysis of an abortion-related law was for this case, yes.

Q. Okay. And you have never done anything before today— never done any cost benefit analysis

on the cost or benefits associated with ambulatory surgical centers?

A. That's correct.

Q. And the same with respect to physician admitting [183] privileges?

A. That's correct.

Q. With respect to the scope of your direct testimony, I just want to make the record clear that you did not do a cost benefit analysis for purposes of the admitting privileges provision of House Bill 2?

A. That's right. I focused solely on the ASC requirement of HB 2.

Q. And you would agree with me, wouldn't you, that when doing a cost benefit study, you would start with looking at all—all of the opinions in looking at a particular issue. So you would want to look at, if there are, say, five different—five different areas where expertise weigh in—experts weigh in with different types of opinions, you would want to look at all of those, wouldn't you?

A. I'm not sure I understand your question. What do you mean by five experts?

Q. Well, if you had—let's say that you have a—a shade of blue, and you have four different artist experts who want to talk about what that—what shade of blue that is. In doing—I know this is a crazy analogy.

A. Yeah. This is a bad example because economists don't look at colors.

Q. But if you wanted to analyze the cost or benefit associated with something like that, you would want to look at [184] the opinions of all four experts in the shade of blue, wouldn't you?

A. If there were only four experts, I would look at each of the four. My experience in cost benefit analysis that there is lots and lots of material. Reading everything is usually not possible. What you try to do is a very careful study of reliable sources. We look for objective opinions and well-founded studies. But reading everything is usually something that's just not feasible to do.

Q. But you would at least try to identify the varying sides of the issue, right?

A. I would look for reliable science.

Q. Sides, right? The varying opinions?

A. I don't go into a cost benefit study with preconceived notions of what sides there are. I look for reliable science.

Q. Okay. And in this particular instance, I believe you testified that you relied on three different doctors for your understanding of abortion procedures, the risk—the risks and complications associated with abortion procedures, and safety of those procedures; is that right?

A. I'm not sure that's right. Are you talking about the three doctors that I spoke with individually?

Q. Yes. Dr. Grimes, Dr. Raymond, and Dr. Grossman.

A. So as I explained in my deposition, I relied on those doctors for different things.

[185] Q. Well, and so the Court is clear, what did you rely on Dr. Grimes for?

A. I spoke with Dr. Grimes about a whole host of subjects. I talked with him about the abortion procedure, about risk factors and risk rates associated with it, about appropriate measures for ensuring safety. I may have listed other things in my deposition. That's what I can think of off the top of my head.

Q. Well, let me just ask you: Isn't it true that Dr. Grimes and Dr. Raymond have worked together in research on abortion services?

A. I know that they have a co-authored paper together. I believe I cite that paper. I don't know what their working relationship is outside of that citation.

Q. And Dr. Raymond was here testifying today. Isn't that true?

A. Yes.

Q. And were you also here when Dr. Grossman testified early this morning?

A. Yes.

Q. And you understand that both of those witnesses were here on behalf of the plaintiffs?

A. Yes.

Q. Right. And you did not, for purposes of your cost benefit analysis, engage any of the defendants' expert witnesses, did [186] you?

A. "Engage" meaning?

Q. You didn't—you didn't look at any of their—the sources that they cited in their expert reports about the health and safety concerns related to abortions?

A. We may have some sources in common. I don't know.

Q. Okay. But you didn't—

A. Our reports were all. I'm sorry.

Q. —you did not specifically analyze the defendants' experts reports?

A. No. They weren't ready. I think all of our reports were due on the same day.

Q. And for purpose of your analysis, you didn't discuss opinions of medical—of any medical practitioners who consider the ambulatory surgical center requirement to be of a benefit to women?

A. I searched on PubMed, which is a source for academic and scientific research. Had a reputable paper been on that site, I would have found it. I didn't see any opinions expressing that.

Q. And you would agree with me, wouldn't you, it would be feasible to conduct a study or some sort of analysis about the risk rates associated with providing abortion services in an ambulatory service center versus risk—risks in providing abortion services outside of an ambulatory service center?

[187] A. You're talking about a primary scientific study that would compare—

Q. Yes.

A. —risks at those two abortions at those two different kinds of providers?

Q. Yes.

A. Would it be—and your question is would it be feasible?

Q. Would a study like that be feasible?

A. I believe it would be.

Q. And you didn't do a study like that, did you?

A. No. I didn't conduct any primary research. I relied on published literature.

Q. You didn't find any published literature that did a study like that, did you?

A. I looked and did not find one. What I did find was an older study that compared abortion risk rates at hospitals versus clinics. And I took that to be informative because the licensing requirements—my understanding of the licensing requirements for abortion performed at hospitals are more stringent than those required at ASCs.

Q. Okay. And you haven't asked any women whether they would prefer to a have an abortion in an ambulatory surgical center or not, did you?

A. I didn't conduct any survey analysis, no.

Q. And you would agree, wouldn't you, that there could be at [188] least one or two people that might disagree with your comparison or the weights of cost and benefits?

A. Well, I'm not—I don't really have to apply weights for costs and benefits. My study found zero benefits and positive costs. And I think just mathematically it's difficult to disagree that a positive number is not larger than zero.

Q. Do you remember when Mr. Stephens took your deposition in this case?

A. Yes, I do.

Q. And do you remember when he asked you whether it was possible that others could differ on that opinion and whether the economic analysis could show that the opinion might be wrong from some

other standpoint? Do you remember him asking you that question?

A. I don't remember him using the words "might be wrong." I think he asked me about whether another economist might disagree with the conclusions.

Q. And your answer to that was an economist could do something like a survey and yet—something, a survey, and show, yes, one or two people might disagree with this comparison or the weighing of these costs and benefits. But just to be fair to you, the majority would agree with it?

A. I think that's from a different portion of the deposition where we were talking about a hypothetical. That was not in relationship to my cost benefit study.

[189] Q. You agree that some regulatory oversight is acceptable, don't you?

A. Yes. I think that's well-accepted.

Q. For—and just so the record is clear, for abortion— provision of abortion services.

A. Let me just restate to make sure I understand.

Q. Some oversight is appropriate and acceptable for the provision of abortion services?

A. It seems to me that regulatory oversight is probably acceptable for all medical procedures.

Q. And you would agree that if the risk rates are lowered when a procedure is performed at an ASC, then there would be some benefit?

A. You—can you repeat that? Did you say if the—

Q. If the risk rates were lowered, yes, when a procedure is performed at an ambulatory surgical center, then that would be of a benefit.

A. If I had found out evidence of reduced risk rates for abortion performed at ASCs compared to non-ASC clinics, that would have been a benefit I would have included as against the costs that were measured.

Q. And with respect to the abortion providers, you haven't studied any of their financial income statements, have you?

A. We did look at financial statements from the—from three of the clinics that were plaintiffs in this. I discussed this [190] in the deposition, I believe. I'm trying to remember what documents there were, but there were some financial elements to that data, operating costs and that sort of thing.

Q. But you cannot say one way or the other whether they can or cannot afford to at some point meet the ASC requirement?

A. I think that requires a forecast of what they anticipate their profits to be as opposed to the higher costs. I did calculate what the higher incremental

operational costs would be, and those are reported in my testimony.

Q. And in terms of—of profits that might be associated with an ambulatory surgical center, what other kinds of procedures can be performed other than abortions when you're looking—when you have surgical centers such as that?

A. I think that depends on how the ASC is set up and what they are prepared to handle. Theoretically, any outpatient surgery procedures could be conducted at an ASC. But, of course, they would have to be geared towards that with the proper equipment and the proper staff.

Q. That's certainly something that the clinics could—could consider for purpose of their own benefit?

A. In a feasibility study and an analysis of the market in terms of demand and prices and whether or not that would offer a profitable return, that would be one thing you could investigate. I'm not here to answer to that investigation.

MS. DAHLBERG: I pass the witness, Your Honor.

[191] THE COURT: Redirect, Mr. Lawrence?

MR. LAWRENCE: Yes, Your Honor.

REDIRECT EXAMINATION

BY MR. LAWRENCE:

Q. Dr. Layne-Farrar, could you give us a little bit of background on where you work?

A. I work at a consulting firm. I'm an economist, and we do economic consulting plus some other kinds of consulting within the firm.

Q. And what's the name of that firm?

A. Charles River Associates. It's headquartered in Boston, but I'm based in Chicago.

Q. And what's your educational background?

A. I received my bachelor's in economics and Indiana University with honors, summa cum laude. I went to graduate school at the University of Chicago and received my master's and my Ph.D. in economics there.

Q. And in your work as an economists, do you perform cost benefit analyses?

A. I do.

Q. And could you give me some examples of some other cost benefit analyses that you've done?

A. These are frequently related to proposed legislation or regulation. So most recently I did one on the Dodd-Frank Act. It's more properly known as the Wall Street Reform Act. One [192] amendment in that Act was the Durbin Amendment, and it regulated

the prices that banks charge one another for debit cards. That's one that I've done recently.

I've done others on the cost and benefits of regulated E-commerce, of decommissioning oil platforms in the Gulf. I did one on legislation that would have regulated how labor unions are formed.

Q. Let's take for example the cost benefit analysis you mentioned about decommissioning oil platforms, you said?

A. Correct.

Q. Are you an expert in offshore drilling?

A. No.

Q. But you were retained to provide cost a benefit analysis in connection with that decommissioning project?

A. Yes. I was retained to do economic analysis, and so I worked—this is common for all manner of cases, not just cost benefit. I worked with the clients and with the documents available for whatever the industry might be, whether it's credit cards, labor unions or oil rigs.

Q. You were asked some questions about your—your communications with, I believe it was, Dr. Grossman and Dr. Raymond in connection with this case.

A. Yes.

Q. Can you please describe what you discussed with—with Dr. Grossman in connection with this case?

[193] A. Yes. I called him early on right after I was retained in order to help guide me in my research, to point me in the direction of where I could find peer-reviewed articles in the field, where I could find resources, data, information that I then went and investigated on my own.

Q. And what about Dr. Raymond? What was—what were your communications with Dr. Raymond?

A. They were the same—early on in the case to help guide my research.

Q. You were asked about the opinions that you provided in your testimony, specifically about the higher operational costs of operating an ASC.

A. Yes.

Q. Could you tell us what your findings are in connection with the higher operational costs for the operation of an ASC?

A. What I found was that the incremental costs of operating an ASC to perform abortions as compared to a non-ASC clinic were approximately 600,000 to 1.4 million a year. And I summarized those in a table in my testimony.

Q. I'm going to try this again. I'm hoping to have better luck with it. Can you see that?

A. I can.

Q. Okay.

THE COURT: It's too little to read, but it's in good focus.

[194] THE WITNESS: I agree.

Q. Dr. Raymond, is this—Dr. Layne-Farrar, is this the table you're referring to?

A. That is. It's a summary of the conclusions that I draw in my report.

Q. If you could briefly just tell us what your conclusions were.

A. Certainly. So I did a cost benefit analysis from two different perspectives. The first perspective was for abortion providers. So would there be any benefit—say, potentially increased profits—that might accrue from the imposition of the ASC requirement in HB 2. I found no evidence of any expected increase in net income or profits for abortion providers, but I did find significant costs.

You've already heard earlier today, some of those costs in terms of the build-out either retrofitting an existing facility, which would cost in excess of $1 million, to the cost of having to build a green field, a brand new AFC facility, which is estimated to cost roughly around $3 million. And then so those are the up-front costs of establishing a new facility that would comply with the HB 2 ASC requirements.

But then once you have done so, you would still have higher operational costs. So I compared the costs of running an abortion facility either via an ASC or a non-ASC clinic, and the costs are listed in that last block there on the right-hand [195] side column. It would increase by approximately 607,000 a year to 1,039,000 a year more to run an ASC.

So the costs would be higher, and there was no evidence that you would be earning a higher profit margin and that you would have to raise the price of providing an abortion to abortion patients in order to cover those higher costs. But I found no evidence that you could do a price increase above that cost amount that would give you a margin of—a greater profit margin. That's the first piece.

Q. What's the second piece?

A. The second piece was a cost benefit analysis from the perspective of abortion patients. And there the benefits potentially could have been any increased improvement in health and safety. So either a reduction in the mortality rate or a reduction in the complication rate. I found no evidence supporting either reduction. There was no evidence suggesting that abortions performed at ASCs were any safer or lower risk in complication rates than abortion performed at non-ASC clinics. And the rates were in fact quite low to begin with.

But I found a number of costs, and those are listed in that second panel on the far right column. And I can walk through those, if you would like.

Q. Please do.

A. Sure. So the first is just a simple economic.

MS. DAHLBERG: Objection. Narrative, Your Honor.

[196] THE COURT: I'll let her have a little leeway on the narrative.

A. Okay. The first is just a simple economic point that, because the clinics west and south of San Antonio are going to close as a result of HB 2, that you'll have a reduction in supply. And as an economic matter, when the supply curve shifts back, that's going to not only mean it's harder to obtain an abortion but it also raises the price of receiving an abortion. So those are first two listed there on the table.

The increased cost of accessing a facility—drive times. I think we heard about those earlier today—in addition to the increased price of the procedure will make it harder for women to obtain one, assuming they can reach a clinic.

And then there are expected increased health risks by delaying getting an abortion procedure because you have to travel farther and it's harder to get to the facilities. You have to raise the money to do so. And the delay is expected to increase health risks to women either from getting an abortion with a greater number of weeks pregnant or because you—the delay pushes you past the period where you can receive one and, therefore, you would expect the rates

of women seeking to self-induce or seeking an illegal abortion would rise as a result.

MR. LAWRENCE: No further questions, Your Honor.

[197] THE COURT: Thank you. Ms. Dahlberg, recross?

MS. DAHLBERG: No further questions.

THE COURT: All right. You may step down.

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS (AUSTIN)

(Admitted Aug. 4, 2014)

Exhibit
16
7/25/14

EXHIBIT
P-020
1:14-CV-284-LY

From: Cooper,Ellen (DSHS)
Sent: Thursday, February 27, 2014 9:40 AM
To: Osborn,Tanya (DSHS)
Cc: Smith,Gina (DSHS)
Subject: RE: abortion performed by patient

My apologies, Tanya. I thought that I replied to your e-mail.

Patient self-induced abortions are not reportable. For the facility to be required to report, the embryo/fetus would have to still be "alive" and fundamentally viable upon presenting at the hospital. If the pregnancy has been terminated prior to presenting at the facility, without the intervention of another facility/ professional, then it is not required to be reported, I hope that this helps.

Thank you,
Ellen

Ellen Cooper, M.S.W., R.N., M.S.N.
Manager, Health Facility Licensing
Division for Regulatory Services

Texas Department of State Health Services
Office (512) 834-6639 Fax (512) 834-4514

From: Osborn,Tanya (DSHS)
Sent: Thursday, February 27, 2014 7:52 AM
To: Smith,Gina (DSHS)
Subject: FW: abortion performed by patient

Good morning, Gina. Would you be able to help with this?

Best regards,

Tanya Osborn
Administrative Assistant
Texas Department of State Health Services
Center for Health Statistics
Data Management Group
P.O. Box 4124
Austin, TX 78765-4124

From: Osborn,Tanya (DSHS)
Sent: Friday, February 21, 2014 12:47 PM
To: Cooper,Ellen (DSHS)
Cc: Baskin,Lyudmila (DSHS)
Subject: FW: abortion performed by patient

Ellen, I received an Induced Abortion Report Form from a hospital reporting "elective induced AB performed at home by patient." I haven't contacted the hospital to clarify, but it looks like the patient presented to the hospital with complications from

attempting her own abortion (Method of Disposal of Fetal Tissue and Remains was "patient disposed at home"). We were wanting to seek clarification from Regulatory about the collection of abortion-by-patient.

Tanya Osborn
Administrative Assistant
Texas Department of State Health Services
Center for Health Statistics
Data Management Group
P.O. Box 4124
Austin, TX 78765-4124

From: Becker,Marcia (DSHS)
Sent: Friday, February 21, 2014 11:57 AM
To: Baskin,Lyudmila (DSHS); Osborn,Tanya (DSHS)
Subject: RE: abortion performed by patient

Yes, contact her please.

Marcia

From: Baskin,Lyudmila (DSHS)
Sent: Friday, February 21, 2014 10:48 AM
To: Osborn,Tanya (DSHS)
Cc: Becker,Marcia (DSHS)
Subject: RE: abortion performed by patient

Tanya,

It is a very unusual case. The law that we follow requires abortion providers to report abortions to the state. Since abortion providers have nothing to do with this abortion, I believe that we do not need this report. But we need to clarify it with the Regulatory. Especially about the Complication form.

Marcia,

Do you want us to contact Ellen Cooper about that? Thank you.

Lyuda

From: Osborn,Tanya (DSHS)
Sent: Friday, February 21, 2014 10:20 AM
To: Baskin,Lyudmila (DSHS)
Subject: abortion performed by patient

Lyuda, I wanted clarification. A received an Induced Abortion Report Form from a hospital which reported "elective induced AB performed at home by patient." I was going to contact the hospital to get further information. It appears that the patient came in with complications from trying to self-abort. Does the State collect information on abortions by patient?

In which case, the hospital who received this patient should also complete an Abortion Complications Form.

Tanya Osborn
Administrative Assistant
Texas Department of State Health Services
Center for Health Statistics
Data Management Group
P.O. Box 4124
Austin, TX 78765-4124

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS (AUSTIN)

(Admitted Aug. 4, 2015)

Exhibit
18
7/25/14

EXHIBIT
P-022
1:14-CV-284-LY

From: Cooper,Ellen (DSHS)
Sent: Thursday, February 27, 2014 8:52 AM
To: Smith,Gina (DSHS)
Cc: Cooper,Ellen (DSHS); Waldron,Patrick (DSHS); Adams,Pamela (DSHS)
Subject: Re: abortion performed by patient

I thought I replied to this previously. I will follow with her.

Ellen Cooper, M.S.W., R.N., M.S.N.
Manager, Health Facility Licensing
Division for Regulatory Services
Texas Department of State Health Services
Office (512) 834-6639 Fax (512) 834-4514

On Feb 27, 2014, at 8:36 AM, "Smith,Gina (DSHS)" <Gina.Smith@dshs.state.tx.us> wrote:

> This sounds like "miscarriage management" like in the article. They didn't perform the abortion. They are cleaning up after she did it herself. I don't think they should report it. Your thoughts? Pat???

Gina Smith, License and Permit Specialist IV
Facility Licensing Group—
Regulatory Licensing Unit
PO Box 149347—Delivery Code 2835
Austin, TX 78714-9347
(512) 834-6646 Fax (512) 834-4514

SIGN UP FOR EMAIL NOTICES:

You may sign up to receive email notices related to health facilities using the contact list on our website at http://www.dshs.state.tx.us/htp/. Near the top of the page you will see a link which says "Sign up for e-mail updates." Future notices about rule changes, stakeholder meetings, and other topics for health facilities will be sent out via this contact list. Please call (512) 834-6648 or (512) 834-6646 if you have any questions. Thank you.

From: Osborn,Tanya (DSHS)
Sent: Thursday, February 27, 2014 7:52 AM
To: Smith,Gina (DSHS)
Subject: FW: abortion performed by patient

Good morning, Gina. Would you be able to help with this?

Best regards,

Tanya Osborn
Administrative Assistant
Texas Department of State Health Services
Center for Health Statistics
Data Management Group

P.O. Box 4124
Austin, TX 78765-4124

From: Osborn,Tanya (DSHS)
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To: Cooper,Ellen (DSHS)
Cc: Baskin,Lyudmila (DSHS)
Subject: FW: abortion performed by patient

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Tanya Osborn
Administrative Assistant
Texas Department of State Health Services
Center for Health Statistics
Data Management Group
P.O. Box 4124
Austin, TX 78765-4124

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Yes, contact her please.

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Marcia,

Do you want us to contact Ellen Cooper about that? Thank you.

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Sent: Friday, February 21, 2014 10:20 AM
To: Baskin,Lyudmila (DSHS)
Subject: abortion performed by patient

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Tanya Osborn
Administrative Assistant
Texas Department of State Health Services
Center for Health Statistics
Data Management Group
P.O. Box 4124
Austin, TX 78765-4124

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS (AUSTIN)

(Admitted Aug. 4, 2014)

Exhibit
5
7/23/14

EXHIBIT
P-024
1:14-CV-284-LY

Mari Robinson

From: Rui Bernardo
Sent: Wednesday, October 09, 2013 6:50 AM
To: Megan Goode
Cc: Mari Robinson
Subject: RE: Heads up from Gov's office on Doc Complaint from DSHS

Good morning Megan,

I wanted to circle back and let you know that I received the complaint regarding this individual on September 30th from the Deputy General Counsel at DSHS. It was assigned log number 14-0609.

Rui Bernardo
Enforcement Support Manager
Texas Medical Board
Office Phone 512-305-7074
Office Fax 512-305-7123

Confidentiality Notice: This message contains confidential information and is intended only for the individual named. If you are not the named addressee you should not disseminate, distribute or copy this

e-mail. Please notify the sender immediately by e-mail if you have received this e-mail by mistake and delete this e-mail from your system.

From: Megan Goode
Sent: Tuesday, September 10, 2013 4:36 PM
To: Rui Bernardo
Cc: Mari Robinson
Subject: Heads up from Gov's office on Doc Complaint from DSHS

Just spoke with Becky Dean at Gov's office—she said that during the DSHS public meeting a few weeks ago on draft rules for HB 2, a physician spoke and stated that she had been practicing as an ob-gyn in Mexico (without license) and had also been bringing back abortion-inducing drugs to the US to give to her patients.

Becky said DSHS was working on getting the physician's name and comments from the transcript and that they would be sending a complaint to us. The name is something like "Julie Klushmidt." She said she'd like to be informed when we get the info from DSHS and I told her we would but that it would be helpful if she had the actual name.

Megan Goode
Governmental Affairs / Communications Manager
Texas Medical Board
(Office) 512-305-7044
(Fax) 512-305-7051
www.tmb.state.tx.us

Mari Robinson

From: Megan Goode
Sent: Wednesday, October 09, 2013 7:59 AM
To: Rui Bernardo
Cc: Mari Robinson
Subject: RE: Heads up from Gov's office on Doc Complaint from DSHS

Ok thnx for info

Sent from my iPhone

On Oct 9, 2013, at 6:50 AM, "Rui Bernardo" <Rui.Bernardo@tmb.state.tx.us> wrote:

> Good morning Megan,
>
> I wanted to circle back and let you know that I received the complaint regarding this individual on September 30th from the Deputy General Counsel at DSHS. It was assigned log number 14-0609.
>
> Rui Bernardo
> Enforcement Support Manager
> Texas Medical Board
> Office Phone 512-305-7074
> Office Fax 512-305-7123
>
> Confidentiality Notice: This message contains confidential information and is intended only for the individual named. If you are not the named addressee you should not disseminate, distribute or copy this e-mail. Please notify the sender immediately by e-mail if you have received this e-mail by mistake and delete this e-mail from your system.

From: Megan Goode
Sent: Tuesday, September 10, 2013 4:36 PM
To: Rui Bernardo
Cc: Mari Robinson
Subject: Heads up from Gov's office on Doc Complaint from DSHS

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Megan Goode
Governmental Affairs / Communications Manager
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(Office) 512-305-7044
(Fax) 512-305-7051
www.tmb.state.tx.us

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS (AUSTIN)

(Admitted Aug. 4, 2014)

EXHIBIT
P-069
1:14-CV-284-LY

Sherwood C. Lynn, Jr., MD, FACOG
802 South Main
McAllen Texas 78501

23 September 2013

Noel Oliveira, M.D.
Chairman, Credentials Committee
Doctors Hospital at Renaissance
5501 South McColl Road
Edinburg TX 78539

Dear Dr. Oliveira,

Would you please send me an application for privileges at the Doctors Hospital at Renaissance? I am in an Ob-Gyn group practice with Whole Woman's Health in McAllen. Alternate coverage will be provided by Dr. Fernando Otero. The office address is 802 S. Main, McAllen, TX 78501 and I can be reached at (251) 605-6691.

Please consider early release of the application.

Thank you for your consideration.

Sincerely
/s/ SC Lynn Jr.
Sherwood C. Lynn, Jr., M.D.

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS (AUSTIN)

(Admitted Aug. 4, 2014)

EXHIBIT
P-068
1:14-CV-284-LY

[LOGO] DOCTORS HOSPITAL
at
RENAISSANCE
5501 South McColl Road—Edinburg, Texas 78539

November 4, 2013

Sherwood C. Lynn, Jr., MD
Whole Woman's Health
802 South Main Street
McAllen, Texas 78501

Dear Dr. Lynn,

The Medical Executive Committee at Doctors Hospital at Renaissance met and reviewed your request for the release of application for privileges for you and your group. The Medical Executive Committee upheld the recommendation of the Credentials Committee to deny your request for application for membership and privileges.

The recommendation was forwarded to the Board of Governors for review and a determination was made not to extend an application to you. Such determination is as authorized under the Bylaws and Rules and Regulations of the Medical Staff for the Hospital. The

decision of the Governing Body was **not** based on clinical competence consideration.

Based on the foregoing, applications will not be forthcoming at this time. Thank you for your interest in our Hospital.

Sincerely,

/s/ Marissa Castañeda
Marissa Castañeda
Chief Operations Officer

No. 15-274

In The
Supreme Court of the United States

WHOLE WOMAN'S HEALTH ET AL. PETITIONERS

v.

KIRK COLE, M.D., COMMISSIONER OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

JOINT APPENDIX
VOLUME IV

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Counsel for Respondents

Petition For Certiorari Filed Sept. 2, 2015
Certiorari Granted Nov. 13, 2015

COCKLE LEGAL BRIEFS (800) 225-6964
WWW.COCKLELEGALBRIEFS.COM

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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS (AUSTIN)

(Admitted Aug. 4, 2014)

DEFENDANT'S EXHIBIT 36

REDACTED

TEXAS DEPARTMENT OF
STATE HEALTH SERVICES
Abortion Complications Reporting

Dept. of State Health Services
RECEIVED

JAN 30 2013

VITAL STATISTICS UNIT

Where and when the abortion was performed:

Facility Name Whole Women's Health of Austin
Date: 12/15/12

Facility Type: _____ License #: _____
Telephone: (877) 6308090

Address: 8401 N. I35 Suit 200 Pflugerville TX 78753
Contact person(s): _____

Type of abortion that caused or may have caused the complication(s): DtC, elective AB.

The number of weeks of gestation at which the abortion was performed: 5 weeks 6 days

Number of patient's previous induced abortions: 0

Number of patient's previous live births: 4

Type of anesthesia used during the procedure:
☒ intravenous sedation ☐ general anesthesia

Where and when the complication was diagnosed and treated *if different* than the above information:

Facility Name and Type: _____
Date: _____

Complications Information (check all that apply):

[ ] Incomplete Abortion
[ ] Post-procedure infection
[x] Hemorrhage
[ ] Damage to the uterus
[ ] Death
[ ] Other

Summary of abortion complication(s):

[x] HCS 767 on 1/17/13, vaginal bleeding, passing large clots on 1/17/13.

Within 20 calendar days of the discovery of the complication:
Return this form **via certified mail** and **marked confidential** to:

Texas Department of State Health Services
Vital Statistics Unit
Post Office Box 4124
Austin, Texas 78765-4124

608

Postmark 07/05/13
—TSO

Dept. of State Health Services
RECEIVED

JUL 11 2013

VITAL STATISTICS UNIT

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Abortion Complications Reporting

Where and when the abortion was performed:

Facility Name Whole Woman's Health, Fort Worth
Date: June 3, 2013

Facility Type: Abortion Facility License #: 14000
Telephone: (817) 377-0614

Address: 3256 Lackland Rd. Fort Worth, Texas 76116
Contact person(s): [redacted]

Type of abortion that caused or may have caused the complication(s): Medical Abortion (Mifeprex, Cytotec)

The number of weeks of gestation at which the abortion was performed: 06 weeks

Number of patient's previous induced abortions: 00

Number of patient's previous live births: 00

Type of anesthesia used during the procedure:
☐ intravenous sedation ☐ general anesthesia

Where and when the complication was diagnosed and treated *if different* than the above information:

Facility Name and Type: _____
Date: _____

Complications Information (check all that apply):

[ ] Incomplete Abortion
[ ] Post-procedure infection
[ ] Hemorrhage
[ ] Damage to the uterus
[ ] Death
[ ] Other

Summary of abortion complication(s):

Patient returned to clinic on June 29, 2013 for regular scheduled follow up appointment. Repeat ultrasound reveled continuing pregnancy. Surgical aspiration completed on June 29, 2013.

Within **20 calendar days of the discovery of the complication**:
Return this form **via certified mail** and **marked confidential** to:

Texas Department of State Health Services
Vital Statistics Unit
Post Office Box 4124
Austin, Texas 78765-4124

Postmark 07/10/13.
—TSO

Dept. of State Health Services
RECEIVED

JUL 18 2013

VITAL STATISTICS UNIT

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Abortion Complications Reporting

Where and when the abortion was performed:

Facility Name Whole Woman's Health, Fort Worth
Date: June 3, 2013

Facility Type: Abortion Facility License #: 14000
Telephone: (817) 377-0614

Address: 3256 Lackland Rd. Fort Worth, Texas 76116
Contact person(s): [redacted]

Type of abortion that caused or may have caused the complication(s): Medical Abortion (Mifeprex, Cytotec)

The number of weeks of gestation at which the abortion was performed: 05 weeks

Number of patient's previous induced abortions: 00

Number of patient's previous live births: 00

Type of anesthesia used during the procedure:
☐ intravenous sedation ☐ general anesthesia

Where and when the complication was diagnosed and treated *if different* than the above information:

Facility Name and Type: _____
Date: _____

Complications Information (check all that apply):

[ ] Incomplete Abortion
[ ] Post-procedure infection
[ ] Hemorrhage
[ ] Damage to the uterus
[ ] Death
[ ] Other

Summary of abortion complication(s):

Pt reported no bleeding following 600mcg of Cytotec. Pt RTC for sono on 05/29/2013, which reveled complete pregnancy. Post-Mife suction preformed on 05/29/2013.

Within **20 calendar days of the discovery of the complication**:
Return this form **via certified mail** and **marked confidential** to:

Texas Department of State Health Services
Vital Statistics Unit
Post Office Box 4124
Austin, Texas 78765-4124

Postmark 07/10/13.
—TSO

Dept. of State Health Services
RECEIVED

JUL 18 2013

VITAL STATISTICS UNIT

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Abortion Complications Reporting

Where and when the abortion was performed:

Facility Name Whole Woman's Health, Fort Worth
Date: June 3, 2013

Facility Type: Abortion Facility License #: 14000
Telephone: (817) 377-0614

Address: 3256 Lackland Rd. Fort Worth, Texas 76116
Contact person(s): [redacted]

Type of abortion that caused or may have caused the complication(s): Medical Abortion (Mifeprex, Cytotec)

The number of weeks of gestation at which the abortion was performed: 05 weeks

Number of patient's previous induced abortions: 02

Number of patient's previous live births: 01

Type of anesthesia used during the procedure:
☐ intravenous sedation ☐ general anesthesia

Where and when the complication was diagnosed and treated *if different* than the above information:

Facility Name and Type: _____
Date: _____

Complications Information (check all that apply):

[ ] Incomplete Abortion
[ ] Post-procedure infection
[ ] Hemorrhage
[ ] Damage to the uterus
[ ] Death
[ ] Other

Summary of abortion complication(s):

Pt. RTC on 05/03/2013 for routine follow up, pt had no complaints, sono showed complete pregnancy still intact, post-mife suction preformed on 05/03/2013.

Within **20 calendar days of the discovery of the complication**:
Return this form **via certified mail** and **marked confidential** to:

Texas Department of State Health Services
Vital Statistics Unit
Post Office Box 4124
Austin, Texas 78765-4124

Postmark 07/10/13.
—TSO

Dept. of State Health Services
RECEIVED

JUL 18 2013

VITAL STATISTICS UNIT

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Abortion Complications Reporting

Where and when the abortion was performed:

Facility Name Whole Woman's Health, Fort Worth
Date: June 3, 2013

Facility Type: Abortion Facility License #: 14000
Telephone: (817) 377-0614

Address: 3256 Lackland Rd. Fort Worth, Texas 76116
Contact person(s): [redacted]

Type of abortion that caused or may have caused the complication(s): Medical Abortion (Mifeprex, Cytotec)

The number of weeks of gestation at which the abortion was performed: 05 weeks

Number of patient's previous induced abortions: 00

Number of patient's previous live births: 03

Type of anesthesia used during the procedure:
☐ intravenous sedation ☐ general anesthesia

Where and when the complication was diagnosed and treated *if different* than the above information:

Facility Name and Type: _____
Date: _____

Complications Information (check all that apply):

[ ] Incomplete Abortion
[ ] Post-procedure infection
[ ] Hemorrhage
[ ] Damage to the uterus
[ ] Death
[ ] Other

Summary of abortion complication(s):

Pt advised that she vomited shortly after taking Mife on 05/02/2013. Pt RTC on 05/04/2013 and sono showed complete pregnancy still present. Post-mife suction completed on 05/04/2013.

Within 20 calendar days of the discovery of the complication:
Return this form **via certified mail** and **marked confidential** to:

Texas Department of State Health Services
Vital Statistics Unit
Post Office Box 4124
Austin, Texas 78765-4124

Dept. of State Health Services
RECEIVED

JUL 18 2013

VITAL STATISTICS UNIT

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Abortion Complications Reporting

Where and when the abortion was performed:

Facility Name Whole Woman's Health, Fort Worth
Date: July 10, 2013

Facility Type: Abortion Facility License #: 14000
Telephone: (817) 377-0614

Address: 3256 Lackland Rd. Fort Worth, Texas 76116
Contact person(s): [redacted]

Type of abortion that caused or may have caused the complication(s): Medical Abortion (Mifeprex, Cytotec)

The number of weeks of gestation at which the abortion was performed: 04 weeks

Number of patient's previous induced abortions: 02

Number of patient's previous live births: 02

Type of anesthesia used during the procedure:
☒ intravenous sedation ☐ general anesthesia

Where and when the complication was diagnosed and treated *if different* than the above information:

Facility Name and Type: _____
Date: _____

Complications Information (check all that apply):

[x] Incomplete Abortion
[ ] Post-procedure infection
[ ] Hemorrhage
[ ] Damage to the uterus
[ ] Death
[ ] Other

Summary of abortion complication(s):

Pt. RTC on 07/10/2013 for second follow up, UCG pregnancy test positive and ultrasound showed continued pregnancy measuring 09 weeks gestation. Resuction completed on July 10, 2013.

Within **20 calendar days of the discovery of the complication**:
Return this form **via certified mail** and **marked confidential** to:

Texas Department of State Health Services
Vital Statistics Unit
Post Office Box 4124
Austin, Texas 78765-4124

Dept. of State Health Services
RECEIVED

JUL 31 2013

VITAL STATISTICS UNIT

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Abortion Complications Reporting

Where and when the abortion was performed:

Facility Name Whole Woman's Health, Fort Worth
Date: July 20, 2013

Facility Type: Abortion Facility License #: 14000
Telephone: (817) 377-0614

Address: 3256 Lackland Rd. Fort Worth, Texas 76116
Contact person(s): [redacted]

Type of abortion that caused or may have caused the complication(s): Medical Abortion (Mifeprex, Cytotec)

The number of weeks of gestation at which the abortion was performed: 04 weeks

Number of patient's previous induced abortions: 00

Number of patient's previous live births: 00

Type of anesthesia used during the procedure:
☐ intravenous sedation ☐ general anesthesia

Where and when the complication was diagnosed and treated *if different* than the above information:

Facility Name and Type: _____
Date: _____

Complications Information (check all that apply):

[x] Incomplete Abortion
[ ] Post-procedure infection
[ ] Hemorrhage
[ ] Damage to the uterus
[ ] Death
[ ] Other

Summary of abortion complication(s):

Pt. RTC on 07/20/2013 concerned that she did not have bleeding following Cytotec. Sono reveled continued pregnancy measuring 7.1 weeks 1mp. Resuction procedure completed on 07/20/2013.

Within **20 calendar days of the discovery of the complication**:
Return this form **via certified mail** and **marked confidential** to:

Texas Department of State Health Services
Vital Statistics Unit
Post Office Box 4124
Austin, Texas 78765-4124

Postmark 10/04/2013.
—TSO

Dept. of State Health Services
RECEIVED

OCT 21 2013

VITAL STATISTICS UNIT

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Abortion Complications Reporting

Where and when the abortion was performed:

Facility Name Whole Woman's Health, Beaumont
Date: July 30, 2013

Facility Type: Abortion Facility License #: AF000079
Telephone: (409) 833-9208

Address: 440 18th Street Suite A Beaumont, TX 77707
Contact person(s): [redacted]

Type of abortion that caused or may have caused the complication(s): Medical Abortion (Mifeprex, Cytotec)

The number of weeks of gestation at which the abortion was performed: 13 weeks

Number of patient's previous induced abortions: 00

Number of patient's previous live births: 00

Type of anesthesia used during the procedure:
☐ intravenous sedation ☐ general anesthesia

Where and when the complication was diagnosed and treated *if different* than the above information:

Facility Name and Type: _____
Date: _____

Complications Information (check all that apply):

[✓] Incomplete Abortion
[ ] Post-procedure infection
[ ] Hemorrhage
[ ] Damage to the uterus
[ ] Death
[ ] Other

Summary of abortion complication(s):

Pt. missed her f/u came in on 7/30/2013 for routine follow up, pt had no sono showed complete pregnancy still intact, post-mife suction preformed on 07/30/2013.

Within **20 calendar days of the discovery of the complication**:
Return this form **via certified mail** and **marked confidential** to:

Texas Department of State Health Services
Vital Statistics Unit
Post Office Box 4124
Austin, Texas 78765-4124

Postmark 10/04/2013.
—TSO

Dept. of State Health Services
RECEIVED

OCT 21 2013

VITAL STATISTICS UNIT

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Abortion Complications Reporting

Where and when the abortion was performed:

Facility Name Whole Woman's Health, Beaumont
Date: August 01, 2013

Facility Type: Abortion Facility License #: AF000079
Telephone: (409) 833-9208

Address: 440 18th Street Suite A Beaumont, TX 77707
Contact person(s): [redacted]

Type of abortion that caused or may have caused the complication(s): Medical Abortion (Mifeprex, Cytotec)

The number of weeks of gestation at which the abortion was performed: 9.2 weeks

Number of patient's previous induced abortions: 00

Number of patient's previous live births: 01

Type of anesthesia used during the procedure:
☐ intravenous sedation ☐ general anesthesia

Where and when the complication was diagnosed and treated *if different* than the above information:

Facility Name and Type: _____
Date: _____

Complications Information (check all that apply):

[✓] Incomplete Abortion
[ ] Post-procedure infection
[ ] Hemorrhage
[ ] Damage to the uterus
[ ] Death
[ ] Other

Summary of abortion complication(s):

Pt. came in for f/u came in on 08/01/2013 for routine follow up, pt had no complaints sono showed complete pregnancy still intact, post-mife suction preformed on 08/06/2013.

Within **20 calendar days of the discovery of the complication**:
Return this form **via certified mail** and **marked confidential** to:

Texas Department of State Health Services
Vital Statistics Unit
Post Office Box 4124
Austin, Texas 78765-4124

Postmark 08/21/2013.
—TSO

Dept. of State Health Services
RECEIVED

AUG 27 2013

VITAL STATISTICS UNIT

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Abortion Complications Reporting

Where and when the abortion was performed:

Facility Name Whole Woman's Health, Fort Worth
Date: August 6, 2013

Facility Type: Abortion Facility License #: 14000
Telephone: (817) 377-0614

Address: 3256 Lackland Rd. Fort Worth, Texas 76116
Contact person(s): [redacted]

Type of abortion that caused or may have caused the complication(s): Suction Cutterage

The number of weeks of gestation at which the abortion was performed: 03 weeks

Number of patient's previous induced abortions: 03

Number of patient's previous live births: 02

Type of anesthesia used during the procedure:
☐ intravenous sedation ☐ general anesthesia

Where and when the complication was diagnosed and treated *if different* than the above information:

Facility Name and Type: _____
Date: _____

Complications Information (check all that apply):

[✓] Incomplete Abortion
[ ] Post-procedure infection
[ ] Hemorrhage
[ ] Damage to the uterus
[ ] Death
[ ] Other

Summary of abortion complication(s):

Pt RTC on August 6, 2013 complaining on nausea and still feeling pregnant. UCG pregnancy test Positive and Sono reveled continued pregnancy with FHT. Resuction procedure completed.

Within **20 calendar days of the discovery of the complication**:
Return this form **via certified mail** and **marked confidential** to:

Texas Department of State Health Services
Vital Statistics Unit
Post Office Box 4124
Austin, Texas 78765-4124

Postmark 09/03/2013.
—TSO

Dept. of State Health Services
RECEIVED

SEP 11 2013

VITAL STATISTICS UNIT

TEXAS DEPARTMENT OF
STATE HEALTH SERVICES
Abortion Complications Reporting

Where and when the abortion was performed:

Facility Name Whole Woman's Health, Fort Worth
Date: August 5, 2013

Facility Type: Abortion Facility License #: 14000
Telephone: (817) 377-0614

Address: 3256 Lackland Rd. Fort Worth, Texas 76116
Contact person(s): [redacted]

Type of abortion that caused or may have caused the complication(s): Suction Cutterage

The number of weeks of gestation at which the abortion was performed: Resuction following D&E at 21 weeks

Number of patient's previous induced abortions: 0

Number of patient's previous live births: 03

Type of anesthesia used during the procedure:
☒ intravenous sedation ☐ general anesthesia

Where and when the complication was diagnosed and treated *if different* than the above information:

Facility Name and Type: _____
Date: _____

Complications Information (check all that apply):

[ ] Incomplete Abortion
[ ] Post-procedure infection
[ ] Hemorrhage
[x] Damage to the uterus
[ ] Death
[ ] Other

Summary of abortion complication(s):

Pt showed to follow up on 07/31/2013, sono reveled RPOC, resuction scheduled for 08/01/2013. During procedure doctor diagnosed a perforation in the uterus. Patient was then transferred to Harris Medical Center for further observation, testing and possible surgery.

Within **20 calendar days of the discovery of the complication**:
Return this form **via certified mail** and **marked confidential** to:

Texas Department of State Health Services
Vital Statistics Unit
Post Office Box 4124
Austin, Texas 78765-4124

Postmark 10/14/13.
—TSO

Dept. of State Health Services
RECEIVED

OCT 21 2013

VITAL STATISTICS UNIT

TEXAS DEPARTMENT OF
STATE HEALTH SERVICES
Abortion Complications Reporting

Where and when the abortion was performed:

Facility Name Austin Whole Woman's Health
Date: 8-24-13

Facility Type: Clinic License #: _____
Telephone: (512) 250-1005

Address: 8401 N IH35 200
Contact person(s): _____

Type of abortion that caused or may have caused the complication(s): elective abortion

The number of weeks of gestation at which the abortion was performed: 11 weeks

Number of patient's previous induced abortions: 0

Number of patient's previous live births: 0

Type of anesthesia used during the procedure:
☑ intravenous sedation ☐ general anesthesia

Where and when the complication was diagnosed and treated *if different* than the above information:

Facility Name and Type: Seton Medical Center Harker Heights Emergency Department

Date: 9-24-13

Complications Information (check all that apply):

[ ] Incomplete Abortion
[ ] Post-procedure infection
[✓] Hemorrhage
[ ] Damage to the uterus
[ ] Death
[✓] Other Pain

Summary of abortion complication(s):

Patient complains of vaginal bleeding and pain related to an abortion completed three weeks ago per the patient.

Within **20 calendar days of the discovery of the complication**:
Return this form **via certified mail** and **marked confidential** to:

Texas Department of State Health Services
Vital Statistics Unit
Post Office Box 4124
Austin, Texas 78765-4124

630

Postmark 10/04/2013
—TSO

Dept. of State Health Services
RECEIVED

OCT 21 2013

VITAL STATISTICS UNIT

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Abortion Complications Reporting

Where and when the abortion was performed:

Facility Name Whole Woman's Health, Beaumont
Date: September 01, 2013

Facility Type: Abortion Facility License #: AF000079
Telephone: (409) 833-9208

Address: 440 18th Street Suite A Beaumont, TX 77707
Contact person(s): [redacted]

Type of abortion that caused or may have caused the complication(s): Medical Abortion (Mifeprex, Cytotec)

The number of weeks of gestation at which the abortion was performed: 7.1 weeks

Number of patient's previous induced abortions: 00

Number of patient's previous live births: 03

Type of anesthesia used during the procedure:
☐ intravenous sedation ☐ general anesthesia

Where and when the complication was diagnosed and treated *if different* than the above information:

Facility Name and Type: _____
Date: _____

Complications Information (check all that apply):

[✓] Incomplete Abortion
[ ] Post-procedure infection
[ ] Hemorrhage
[ ] Damage to the uterus
[ ] Death
[ ] Other

Summary of abortion complication(s):

Pt. came in on 9/12/13 for her medical AB pt. c/o keeping cyto in her cheek for 10min. Pt. came in on 9/14/13 for an sono u/s revealed continued pregnancy. R/S was completed on 9/14/2013.

Within **20 calendar days of the discovery of the complication**:
Return this form **via certified mail** and **marked confidential** to:

Texas Department of State Health Services
Vital Statistics Unit
Post Office Box 4124
Austin, Texas 78765-4124

Dept. of State Health Services
RECEIVED
OCT 29 2013
VITAL STATISTICS UNIT

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Abortion Complications Reporting

Where and when the abortion was performed:

Facility Name Whole Woman's Health, Fort Worth
Date: October 21, 2013

Facility Type: Abortion Facility License #: 14000
Telephone: (817) 377-0614

Address: 3256 Lackland Rd, Fort Worth, Texas 76116
Contact person(s): [redacted]

Type of abortion that caused or may have caused the complication(s): Suction Cutterage

The number of weeks of gestation at which the abortion was performed: 05 weeks

Number of patient's previous induced abortions: 00

Number of patient's previous live births: 01

Type of anesthesia used during the procedure:
☐ intravenous sedation ☐ general anesthesia

Where and when the complication was diagnosed and treated *if different* than the above information:

Facility Name and Type: _____
Date: _____

Complications Information (check all that apply):

[x] Incomplete Abortion
[ ] Post-procedure infection
[ ] Hemorrhage
[ ] Damage to the uterus
[ ] Death
[ ] Other

Summary of abortion complication(s):

Pt RTC on September 26, 2013 scheduled follow up appointment. Patient complained of continued pregnancy symptoms. Sono reveled continued pregnancy with fetal heart tones. Resuction completed on October 21, 2013.

Within **20 calendar days of the discovery of the complication**:
Return this form **via certified mail** and **marked confidential** to:

Texas Department of State Health Services
Vital Statistics Unit
Post Office Box 4124
Austin, Texas 78765-4124

Dept. of State Health Services
RECEIVED

DEC 16 2013

VITAL STATISTICS UNIT

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Abortion Complications Reporting

Where and when the abortion was performed:

Facility Name Whole Woman's Health, Beaumont
Date: Nov. 11, 2013

Facility Type: Abortion Facility License #: 008137
Telephone: (409) 3833-9208

Address: 440 18th Street Suite A Beaumont, TX 77707
Contact person(s): [redacted]

Type of abortion that caused or may have caused the complication(s): Medical Abortion (Mifeprex, Cytotec)

The number of weeks of gestation at which the abortion was performed: 06 weeks

Number of patient's previous induced abortions: 01

Number of patient's previous live births: 00

Type of anesthesia used during the procedure:
☐ intravenous sedation ☐ general anesthesia

Where and when the complication was diagnosed and treated *if different* than the above information:

Facility Name and Type: _____
Date: _____

Complications Information (check all that apply):

[✓] Incomplete Abortion
[ ] Post-procedure infection
[ ] Hemorrhage
[ ] Damage to the uterus
[ ] Death
[ ] Other

Summary of abortion complication(s) Pt. called clinic on 10/18/2013 concerned about being nauseated and lower back pain. Pt. came in to be examine on 10/18/2013 u/s revealed continued pregnancy. Scheduled pt. t come in on 10/22/2013 for a post-mife suction.

Within **20 calendar days of the discovery of the complication**:
Return this form **via certified mail** and **marked confidential** to:

Texas Department of State Health Services
Vital Statistics Unit
Post Office Box 4124
Austin, Texas 78765-4124

Dept. of State Health Services
RECEIVED

JAN 07 2014

VITAL STATISTICS UNIT

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Abortion Complications Reporting

Where and when the abortion was performed:

Facility Name Whole Woman's Health, Beaumont
Date: December 03,2013

Facility Type: Abortion Facility License #: 008137
Telephone: (409) 833-9207

Address: 440 N 18th Street Beaumont, Texas 77707
Contact person(s): [redacted]

Type of abortion that caused or may have caused the complication(s): Suction Cutterage

The number of weeks of gestation at which the abortion was performed: 06 weeks

Number of patient's previous induced abortions: 00

Number of patient's previous live births: 00

Type of anesthesia used during the procedure:
☑ intravenous sedation ☐ general anesthesia

Where and when the complication was diagnosed and treated *if different* than the above information:

Facility Name and Type: _____
Date: _____

Complications Information (check all that apply):

[ ] Incomplete Abortion
[ ] Post-procedure infection
[ ] Hemorrhage
[ ] Damage to the uterus
[ ] Death
[x] Other

TSO
01/21/14

Summary of abortion complication(s):

Pt RTC on December 03, 2013 scheduled follow up appointment. Patient complained of continued pregnancy symptoms. Sono reveled continued pregnancy with fetal heart tones. Resuction completed on December 03, 2013.

Within **20 calendar days of the discovery of the complication**:
Return this form **via certified mail** and **marked confidential** to:

Texas Department of State Health Services
Vital Statistics Unit
Post Office Box 4124
Austin, Texas 78765-4124

Postmark 01/09/14.
—TSO

Dept. of State Health Services
RECEIVED

JAN 14 2014

VITAL STATISTICS UNIT

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Abortion Complications Reporting

Where and when the abortion was performed:

Facility Name Whole Woman's Health, Fort Worth
Date: December 14, 2013

Facility Type: Abortion Facility License #: 14000
Telephone: (817) 377-0614

Address: 3256 Lackland Rd. Fort Worth, Texas 76116
Contact person(s): [redacted]

Type of abortion that caused or may have caused the complication(s): Suction Cutterage

The number of weeks of gestation at which the abortion was performed: 05 weeks

Number of patient's previous induced abortions: 00

Number of patient's previous live births: 01

Type of anesthesia used during the procedure:
☐ intravenous sedation ☐ general anesthesia

Where and when the complication was diagnosed and treated *if different* than the above information:

Facility Name and Type: _____
Date: _____

Complications Information (check all that apply):

[x] Incomplete Abortion
[ ] Post-procedure infection
[ ] Hemorrhage
[ ] Damage to the uterus
[ ] Death
[ ] Other

Summary of abortion complication(s):

Pt. RTC on 01/03/2014 for routine follow up. UCG results positive and sono revealed continuing pregnancy. Resuction procedure completed on 01/03/2014.

Within **20 calendar days of the discovery of the complication**:
Return this form **via certified mail** and **marked confidential** to:

Texas Department of State Health Services
Vital Statistics Unit
Post Office Box 4124
Austin, Texas 78765-4124

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS (AUSTIN)

(Admitted Aug. 4, 2014)

DEFENDANT'S EXHIBIT 39

[LOGO] **Whole Woman's Health**
Complication Log

Month of August 2013 Start Date (this page): 08/01/2013 End Date (this page): 08/31/2013

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
8/6/13	Redacted	7/26/13	nausea/pregnancy 3/3x	resuction completed 08/06/13 Bicornate UT.	MS	AM
8/1/13		7/16/13 @ ASC w SA	left abdominal pain	pt. transferred to HMC Dl: uterine perforation	MS	AM

REDACTED

[LOGO] **Whole Woman's Health**

Complication Log

Month of July 2013 Start Date (this page): 07/01/13 End Date (this page): 07/31/13

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
7/10/13	Redacted	06-01-13	cont. pregnancy 3/3x	resuction 7/10/13	MS	AM
7/20/13		07-15-13	~~co~~ 0 bleeding to Cyto	resuction 7/20/13	MS	AM

[LOGO] **Whole Woman's Health**

Complication Log

Month of June 2013 Start Date (this page): 06/01/13 End Date (this page): 06/30/13

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
6/29/13	Redacted	Mife 6/8/13	~~Aone~~ MS preg 5x Suno reveled cont. preg.	Resuction	MS	AM

[LOGO] **Whole Woman's Health**
Complication Log
Month of May 2013 Start Date (this page): 05/01/13 End Date (this page): 05/31/13

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
5/4/13	Redacted	5/2/13	Unable to keep Mife down on 5/2/13	post-Mife suction 5/4/13	MS	AM
5/29/13		5/24/13	0 bleeding—Cytotec	post-Mife suction 5/29/13	MS	AM
5/3/13		4/19/13	none	Failed Mife post-mife suction 5/5/13	MS	AM

[LOGO] **Whole Woman's Health**

Complication Log

Month of March 2013 Start Date (this page): 3/1/13 End Date (this page): 3/31/13

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
3/7/13	Redacted	3/5/13 Mife	Severe cramping vomiting	failed Mife resuction ordered by Dr. Kraus	MS	AM
3/4/13		3/21/13 Mife	pregnancy 3x	failed Mife resuction ordered by Dr. Kraus	MS	AM

[LOGO] **Whole Woman's Health**

Complication Log

Month of February Start Date (this page): 2/25/13 End Date (this page): _____

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
2/25/13	Redacted	2/8/13 Mife	Pt. stated hasn't hardly any bleeding since taking Cyto on day 20 vaginal itching	per West for resuction failed Mife, sono during f/u & showed uterus not empty	SA	AM
2/13/13		11/23/12	Pt. didn't have menss since TOP 11/23/12 2 am test had been neg 0 didnt come in for f/u	sono was done 2/13/13 uterus wasn't clear per [redacted] to have resuction	SA	AM

[LOGO] **Whole Woman's Health**
Complication Log
Month of January Start Date (this page): 1/15/13 End Date (this page): _____

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
1/15/13	Redacted	12/22 Top	Continued viable pregnancy seen @ f/u on 1/7/13	resuctions per [redacted]	BIA	AM
1/26/13		1/12/13 Mife	Pt. stated to have lots of lower abdominal per cramping. Doesn't feel right/clots seen on sono	resuc—per [redacted]	SA	AM

[LOGO] **Whole Woman's Health**

Complication Log

Month of December Start Date (this page): 12/1/12 End Date (this page): 12/31/12

Patient Label ***Name/DOB/DOS MD/MR#***	**Date of TOP**	**Complication**	**Same Day Return to OR Y/N**	**Hospital Transfer Y/N**	**Resolution**	**Staff Initials**	**Medical Director Initials**
Redacted	12-13-12	Abdominal pain cramping—[illegible] blood clots	N	N	pt seen & tx [illegible] Cytotec [illegible] @ clinic. Rx given	@	SW

[LOGO] **Whole Woman's Health**

Complication Log

Month of November Start Date (this page): 11/1/12 End Date (this page): 11/30/12

Patient Label ***Name/DOB/DOS MD/MR#***	**Date of TOP**	**Complication**	**Same Day Return to OR Y/N**	**Hospital Transfer Y/N**	**Resolution**	**Staff Initials**	**Medical Director Initials**
~~NO~~	~~COMPL~~						
Redacted	11/1/12	[Illegible] clots cramping, bleeding	N	N	Resolution	@	SW

[LOGO] **Whole Woman's Health**

Complication Log

Month of October Start Date (this page): 10/1/12 End Date (this page): 10/31/12

Patient Label ***Name/DOB/DOS MD/MR#***	**Date of TOP**	**Complication**	**Same Day Return to OR Y/N**	**Hospital Transfer Y/N**	**Resolution**	**Staff Initials**	**Medical Director Initials**
_____NO COMPLI	CATIONS	[ILLEGIBLE] _____			_____	@	SW

[LOGO] **Whole Woman's Health**
Complication Log
Month of September 2012 Start Date (this page): 9/1/12 End Date (this page): 9/30/12

Patient Label ***Name/DOB/DOS MD/MR#***	**Date of TOP**	**Complication**	**Same Day Return to OR Y/N**	**Hospital Transfer Y/N**	**Resolution**	**Staff Initials**	**Medical Director Initials**
Redacted	9/20/12	post-op bleeding	Y	Y	ER transfer fluid therapy	@	SW

[LOGO] **Whole Woman's Health**

Complication Log

Month of January Start Date (this page): 1/1/12 End Date (this page): 1/31/12

Patient Label ***Name/DOB/DOS MD/MR#***	**Date of TOP**	**Complication**	**Same Day Return to OR Y/N**	**Hospital Transfer Y/N**	**Resolution**	**Staff Initials**	**Medical Director Initials**
Redacted	1/5/12	[Illegible] [Illegible] pain not [Illegible] meds (Transferred from perform	N previously	N [Illegible])	post Mife—suction [Illegible] [Illegible]	@	SW

[LOGO] **Whole Woman's Health**
Resuction Log

Month of {blank}

Patient Name and DOB	MD Performed TOP	Surgical or Mifeprex	Date of Abortion	MD Performed Resutcion	Date of Resuction	Retained clots	Retained POC (pos UCG or incomplete AB)	Continued pregnancy	Missed AB—nonviable sac present	Other treatment attempted before resuction? If yes, what tx?	Staff initials	Medical Director Initials
		mife	5/31 2013	[redacted]	6/22 2013		X				[Illegible]	[Illegible]
		surgical	5/16 2013		5/30 2013		X				[Illegible]	[Illegible]
		mife	4/18 2013		5/16 2013		X				[Illegible]	[Illegible]
		surgical	5/4 2013		5/9 2013		X				[Illegible]	[Illegible]
		mife	4/13 2013		5/4 2013		X				[Illegible]	[Illegible]

Revised Feb 2010 AHM

[LOGO] **Whole Woman's Health**
Resuction Log

Month of (blank)

Patient Name and DOB	MD Performed TOP	Surgical or Mifeprex	Date of Abortion	MD Performed Resutcion	Date of Resuction	Retained clots	Retained POC (pos UCG or incomplete AB)	Continued pregnancy	Missed AB—nonviable sac present	Other treatment attempted before resuction? If yes, what tx?	Staff initials	Medical Director Initials
[redacted]		surgical	9/6 2013	[redacted]	9/24 2013	X	X				[Illegible]	[Illegible]
		mife	6/11 2013		7/30 2013		X				[Illegible]	[Illegible]
		mife	6/8 2013		7/12 2013		X				[Illegible]	[Illegible]
		mife	6/19 2013		7/5 2013		X				[Illegible]	[Illegible]
		mife	6/8 2013		6/29 2013		X				[Illegible]	[Illegible]

[LOGO] **Whole Woman's Health**
Resuction Log

Month of (blank)

Patient Name and DOB	MD Performed TOP	Surgical or Mifeprex	Date of Abortion	MD Performed Resutcion	Date of Resuction	Retained clots	Retained POC (pos UCG or incomplete AB)	Continued pregnancy	Missed AB—nonviable sac present	Other treatment attempted before resuction? If yes, what tx?	Staff initials	Medical Director Initials
[redacted]		mife		[redacted]	12/21 2013		X				[Illegible]	[Illegible]
		surgical	11/8 2013		11/13 2013	X	X				[Illegible]	[Illegible]
		mife	10/16 2013		11/8 2013		X				[Illegible]	[Illegible]
		mife	10/12 2013		10/25 2013		X				[Illegible]	[Illegible]
		surgical	9/00 2013		10/5 2013	X	X				[Illegible]	[Illegible]

Revised Feb 2010 AHM

[LOGO] **Whole Woman's Health**
Resuction Log

Month of (blank)

Patient Name and DOB	MD Performed TOP	Surgical or Mifeprex	Date of Abortion	MD Performed Resutcion	Date of Resuction	Retained clots	Retained POC (pos UCG or incomplete AB)	Continued pregnancy	Missed AB—nonviable sac present	Other treatment attempted before resuction? If yes, what tx?	Staff initials	Medical Director Initials
		surgical	2/8 2013		2/14 2013		X				[Illegible]	[Illegible]
		surgical	2-11-13		2/14 2013		X				[Illegible]	[Illegible]
		surgical	1-11-13		1-30-13	X	X				[Illegible]	[Illegible]
		~~[illegible]~~ Mife	1-11-13		1-30-13		X				[Illegible]	[Illegible]
		surgical ~~[illegible]~~	1-19-2013		1-30-13		X				[Illegible]	[Illegible]

[LOGO] **Whole Woman's Health**
Resuction Log

Month of (blank)

Patient Name and DOB	MD Performed TOP	Surgical or Mifeprex	Date of Abortion	MD Performed Resutcion	Date of Resuction	Retained clots	Retained POC (pos UCG or incomplete AB)	Continued pregnancy	Missed AB—nonviable sac present	Other treatment attempted before resuction? If yes, what tx?	Staff initials	Medical Director Initials
[redacted]		surgical	3/30 2013	[redacted]	4/23 2013		X				[Illegible]	[Illegible]
		mife	3/30 2013		4/13 2013		X				[Illegible]	[Illegible]
		mife	2/20 2013		3/6 2013		X				[Illegible]	[Illegible]
		mife	2/8 2013		2/27 2013		X				[Illegible]	[Illegible]
		surgical	11-29-13		2/20 2013	X	X				[Illegible]	[Illegible]

[LOGO] **Whole Woman's Health**
Resuction Log
Month of (blank)

Patient Name and DOB					
MD Performed TOP					
Surgical or Mifeprex	mife		mife		
Date of Abortion	1/22/14				
MD Performed Resutcion	[redacted]				
Date of Resuction	1/30/14	3/29/14	3/29/14		
Retained clots			X		
Retained POC (pos UCG or incomplete AB)	/	X			
Continued pregnancy					
Missed AB—nonviable sac present					
Other treatment attempted before resuction? If yes, what tx?					
Staff initials		[Illegible]	[Illegible]		
Medical Director Initials	[Illegible]				

[LOGO] **Whole Woman's Health**

Complication Log

Month of December Start Date (this page): _____ End Date (this page): _____

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
12-7-12	Redacted	11-23-12 (Mife)	Continued pregnancy nonviable/Pt. threw up Cyto	per [redacted] resuction	SQ	AM
12/10/12		11/27/12 (Mife)	Pt. came in for Mife f/up & test is sono and show uterus to have something in it	Dr. [redacted] reviewed chart of per [redacted] resuction would be best	SQ	AM
12/22/12		12/4/12 (Mife)	Pt. came in for f/u 12/22/12 sono shows viable pregnancy	Dr. [redacted] to resuction	SQ	AM

[LOGO] **Whole Woman's Health**
Complication Log
Month of November Start Date (this page): 11/1/12 End Date (this page): _____

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
11/1/12	Redacted	10-6-12	Clots were visible on f/u 10/18/12 per [redacted] 600 Cyto [Illegible] 1/1/12 for possible resuc-	11-2-12 Pt. came in for resuction by Kraus	SQ	AM
11-19-12		11-14-12	Bleeding-clots	Pt. came in for sono uterus had visible clots & lower pain per [redacted] to view sono best to have resuction for pt.	SQ	AM
11/23/12		11/8/12 Mife	Sono shows to have some clots 10 ft in uterus on #up 11/23/12	Per [redacted] to resuction Pt. came back on 12/10/12 FUP & fine	SQ	AM
11-28-12		11/15/12 Mife	Pos @ f/up large visible clots in uterus	Per [redacted] to resuction on 11/28	SQ	AM
11/28/12		11/24/12	Pt. called 4 days later with complaints of chills nausea advised to come in for sono to make sure pregnancy wasn't con- tained	Per [redacted] to resuction sono showed uterus to have large clots possible pregnancy left	SQ	AM

[LOGO] **Whole Woman's Health**
Complication Log
Month of October Start Date (this page): 10/1/12 End Date (this page): _____

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
10/20/12	Redacted	9-26-12	Pt. came in ~~10/8/12~~ 10/5/12 w/pains cramping large clots	Per [redacted] gave 600 Cyto to relieve clots shown in sono 10/13 [redacted] resuc-	SQ	AM
10/15/12		9-25-12	Clots pain & large clots	Per [redacted] to resuction	SQ	AM
10/9/12		9-25-12	Pain & fever	Per [redacted] to resuction sono showed clots on f/u	SQ	AM
~~10/6/12~~						

[LOGO] **Whole Woman's Health**

Complication Log

Month of September Start Date (this page): 9/1/12 End Date (this page): _____

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
9/7/12	Redacted	8/30/12	0 bleeding/clots extremely bad cramping	Pt. to come in for sono 8/30/12 possible resuction if needed	SQ	AM
9/26/12		9/1/12 Mife	Continued pregnancy when came in for HUD 9/26	[redacted] after seeing sono to repeat TOP	SQ	AM
9/11/12		9/11/12	Pt. started hemorrhaging was taken to JPS Hosp.	Pt. is ok hospital performed hyster-ectomy	SQ	AM

[LOGO] **Whole Woman's Health**
Complication Log
Month of August Start Date (this page): 8/11/12 End Date (this page): _____

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
8/1/12	Redacted	7/27/12 (Mife)	Pt. feels pregnant only been 4 days, lots of vomitting	Sono showed pregnancy still present resuction per [redacted]	SA	AM
8/21/12		8/7/12	Bleeding large clots, dizzy feeels pregnant still	Per [redacted] 600 Cyto today & pt return for 2 wks. for resono to see clots have passed 9/4/12 [redacted] resuction pt.	SA	AM
8/24/12		8/2/12 (Mife)	Pt. complained of bleeding badly 0 pain	Pt. had some clots left in uterus on f/u 8/21/12 per [redacted] 600 Cyto & return following wk, but pt came in next day complaining of bleeding heavy explained this was to happen [Illegible] for persons uterus appeared much clearer	SA	AM

[LOGO] **Whole Woman's Health**

Complication Log

Month of July 2012 Start Date (this page): 6 7/1/12 End Date (this page): _____

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
7-9-12	Redacted	Mife 7-5-12	pain in lower abdomen	per [redacted] to resuction	SA	AM

[LOGO] **Whole Woman's Health**
Complication Log
Month of June 2012 Start Date (this page): 06/01/12 End Date (this page): 06/30/12

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
6/6/12	Redacted	5/22/12 Mife	pos pregnancy test sono showed continued pregnancy	Resuction	MS	AM
6/7/12		5/16/12 Mife	sono shows possible clots in uterus	Per [redacted] give end round of 600 Cyto & return for sono on 6/11/12 to see if any clots have gone	SQ	AM
6/7/12		6/2/12 TOP	Pt. complaining of severe pain, abdominal & clots large sono showed to have many clots in uterus	[redacted] resuctioned	SQ	AM
6/8/12		5/22/12	Pt. came in for f/u Mife preg. UCG shows 0 sono showed to have possible clots in uterus	Per [redacted] 800 Cyto to pass clots & return 6/11/12 for resono & go from there/pt. came in 6/11/12 and uterus appears empty & neg - pretest	SQ	AM
6/9/12		5/30/12	Pt. still feels pregnant sono showed pregnancy still there [redacted] did advise pregnancy can be missed & have precautions. Early pregnancy 5-3	[redacted] to do resuction	SQ	AM
6/11/12		5/26/12	Mife—came in for f/u to see if neg - but sono shows there is possible clots in uterus	Per [redacted] 2nd end of Cyto to clear uterus up & will return 6/14/12 for resono	SQ	AM

[LOGO] **Whole Woman's Health**

Complication Log

Month of May Start Date (this page): 5/01/2012 End Date (this page): 5/31/12

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
5-7-12	Redacted	Mife 4-18-12	Uterus appears to have some clots present	Per [redacted] to resuction Pt. didn't return was going to own PCC for clots	SQ	AM
5-7-12		Mife 4-19-12	retained clots	Per [redacted] to resuction 5/15/12 pt. came in for resono & uterus appears to be empty 0 clots	SQ	AM

[LOGO] **Whole Woman's Health**

Complication Log

Month of April 2012 Start Date (this page): 04/01/2012 End Date (this page): _____

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
4/5/12	Redacted	3/27/12	Clotting, abdominal pain	resuction	MS	AM
4-25-12		4-19-12	Pt. states feels pregnant still & went to ER sono says preg- is there	resuction	SQ	AM

[LOGO] **Whole Woman's Health**

Complication Log

Month of March Start Date (this page): 3/1/12 End Date (this page): _____

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
3/3/2012	Redacted	2/17/12 (Mife)	Retained tissue from Mife, Pt. came in for f/u 3/2/12 had + test	Per [redacted] gave 800 Cyto on 3/2/12 to resolve came back 5/3/12 still visible tissue [redacted] will suction	SQ	AM
3-10-12		2/24/12 (Mife)	retained clots & tissue seen on sono @ f/u 3/8/12	[redacted] will perform resuction	SQ	AM
3-13-12		2/28/12 (Mife)	appears tissue 2 in f/u sono	[redacted] performing resuction	SQ	AM
3-5-12		2/16/12 (Mife)	came in for f/u 2 UCG +/sono doesn't appear empty	Dr. [redacted] performed resuction	SQ	AM
~~3-15-12~~		~~2/29/12 (Mife)~~	~~preg test + @ f/up & symptoms of pregnancy still cramping bad & bleeding 14 days straight~~	~~Pt. will come in 3/16/12 for Mife resuction~~	~~SQ~~	

[LOGO] **Whole Woman's Health**

Complication Log

Month of February Start Date (this page): 2/1/12 End Date (this page): _____

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
2-20-12	Redacted	Mife 2-7-12	came in for f/u & sono showed several clots 2-20-12	Per [redacted] 600 Cyto repeat sono 2-27-12	SQ	AM

[LOGO] **Whole Woman's Health**

Complication Log

Month of January Start Date (this page): 1/1/2012 End Date (this page): _____

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
2-16-12	Re-dacted	Mife 1-28-12	Came in for F/U & pregtest 2-9-12	Per [redacted] 600 Cyto vaginal to clear clots/return 2/16/12 repeat sono & test	SQ	AM

[LOGO] **Whole Woman's Health**
Complication Log

Month of _____ Start Date (this page): _____ End Date (this page): _____

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials

Revised Feb 2010 AHM

Whole Woman's Health **Complication Log**

Month of Jan. 2011 Start Date (this page): 01/11/11 End Date (this page): 02/20/11

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
01/11/11	Redacted	12/30/10	Pain, bleeding (R POC)	Resuction	SQ	LD
02/03/11		02/03/11	fever w/infection	D&C Hospitalization	SQ	LD
02/10/11		02/10/11	Uterine perforation	Hospitalization 2 units of blood Hysterectomy	SQ	LD
02/23/11		02/23/11	Severe pain post-Laminaria	Laminaria removed same night	SQ	LD
02/24/11		02/24/11	Pain & bleeding post D&E.	Resuction same day. Hospital transfer due to bleeding	SQ	LD
02/24/11		02/24/11	Severe bleeding during procedure Poss. Perf.	transfered to Hospital incomplete D&E. R/O Perf.	SQ	LD

Whole Woman's Health **Complication Log**

Month of MARCH. 2011 Start Date (this page): 03/24/11 End Date (this page): 8/31/11

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
03/24/11	Redacted	(Mife) 03/11/11	Pregnancy symptoms & UCG @ f/u	Resuction (Post-Mife)	SQ	SW
04/21/11		04/21/11	Severe bleeding & pain immediately Post-op Uterine Perforation	Transfer to ER. Hysteroctomi 4-units of blood	SQ	SW
05/05/11		05/05/11	Severe bleeding Post-op. Placenta Secondi Cervical Laceration	Transfer to ER. Resuction (removed 2nd placenta) suture of laceration.	SQ	SW
06/08/11		05/04/11	Pt. called w/pain. "[Illegible] clot" Pt. went to ER. was addmitted	(infection) [illegible] to re-fused to clinic w/Antibiotics	SQ	SW
08/11/11		08/11/11	Cervical Laceration	suture	SQ	SW
08/17/11		07/15/11 (Mife)	f/u received cont. pregnancy. Failed Mife.	suction	SQ	SW

Whole Woman's Health **Complication Log**

Month of September 2011 Start Date (this page): 9/1/11 End Date (this page): 9/30/11

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
09/09/11	Redacted	07/06/11	R POC: pt. went to ER (severe cramps & bleeding)	Resuction	SQ	SW

[LOGO] **Whole Woman's Health**

Complication Log

Month of September 2012 Start Date (this page): 9/1/12 End Date (this page): 9/30/12

Patient Label ***Name/DOB/DOS MD/MR#***	**Date of TOP**	**Complication**	**Same Day Return to OR Y/N**	**Hospital Transfer Y/N**	**Resolution**	**Staff Initials**	**Medical Director Initials**
Redacted	9/20/12	post-up bleeding	Y	Y	ER transfer fluid therapy	SQ	SW

[LOGO] **Whole Woman's Health**
Complication Log
Month of December Start Date (this page): 12/1/2011 End Date (this page): _____

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
12/3/11	Redacted	12/3/11	bleeding p̄ procedure poss acreda tear	transported to ER @ Harris [illegible] to be seen by Gyn [redacted]	MS	AM
12/12/11		10/26/11	cramping & bleeding sono revealed retained clots	resuction12/13/11	MS	AM
12/17/11		12/2/11	pt. feeling pregnancy symptoms	resuction	SQ	AM
12/17/11		12/2/11 mifeprex	retained clots & tissue	Resuction 12/17/11	SQ	AM

Whole Woman's Health **Complication Log**

Month of November Start Date (this page): 11/01/11 End Date (this page): 11/30/2011

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
11/01/11	Redacted	10/14/11	nausea & positive pregnancy	Resuction completed	LB	AM
11/08/11		10/25/11	nausea & positive pregnancy test Fail MIFE	Resuction	[Illegible]	AM
11/26/11		11/26/11	depressed respirations procedure (12.0 LMP)	pt. transported to ER & FPS	MS	AM

[LOGO] **Whole Woman's Health**
Complication Log
Month of October Start Date (this page): 10/1/11 End Date (this page): 10/31/11

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
10-1-11	Redacted	9-20-11	retained clots & F/U	resuction	MS	AM
10-17-11		9-27-11	retained clots	resuction	MS	AM

[LOGO] **Whole Woman's Health**
Complication Log
Month of August Start Date (this page): 08/01/11 End Date (this page): 08/31/11

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
08/20/11	Redacted	MIFE 07/02/11	Failed MIFE	Resuction	CA	AM
08/25/11		MIFE 08/10/11	Failed MIFE	Resuction	CA	AM
08/25/11		MIFE 08/20/11	retained clots	Resuction	CA	AM

[LOGO] **Whole Woman's Health**

Complication Log

Month of July 2011 Start Date (this page): 07/01/11 End Date (this page): 07/31/11

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
07/21/11	Redacted	06/21/11		Resuction	CA	AM
07/21/11		07/21/11	Failed MIFE	Resuction	CA	AM
10/0711		10/07/11	Bleeding & clots cramping	[illegible] seen Resuction [illegible]	LB	AM

[LOGO] **Whole Woman's Health**

Complication Log

Month of June 2013 Start Date (this page): 6/1/13 End Date (this page): 6/30/13

Patient Label ***Name/DOB/DOS MD/MR#***	**Date of TOP**	**Complication**	**Same Day Return to OR Y/N**	**Hospital Transfer Y/N**	**Resolution**	**Staff Initials**	**Medical Director Initials**
Redacted	6/21/13	Failed Mife—post suction post-up bleeding	N	Y	Transferred to Mission Hills Baptist via EMS blood products/IVf therapy	SQ	SW
	6/22/13	Swelling on hands & feet	N	N	Pt sent to ER MD notified (Spanish)	SQ	SW

[LOGO] **Whole Woman's Health**

Complication Log

Month of June Start Date (this page): 6-1-13 End Date (this page): 6-30-13

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials

No Complication

[redacted]

[LOGO] **Whole Woman's Health**

Complication Log

Month of July Start Date (this page): 7-1-13 End Date (this page): 7-31-13

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials

No Complications

[Illegible]

[LOGO] **Whole Woman's Health**
Complication Log

Month of August Start Date (this page): 8-1-13 End Date (this page): 8-30-13

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
8/30/13	Redacted	82913	heavy bleeding, & <2 pads & 1hr. 8/10 pain lower Abd. 0 fever	Sent to University OB SR for further assessment	KH	
	10-9-81		Pt called to report she passed/fainted at home & went to ER	Pt went to ER for evaluation	KH	

[LOGO] **Whole Woman's Health**

Complication Log

Month of September Start Date (this page): 9-1-13 End Date (this page): 9-30-13

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials

No Complications

[redacted]

[LOGO] **Whole Woman's Health**
Complication Log
Month of October Start Date (this page): 01 End Date (this page): 31

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials

No Complications

[redacted]

[LOGO] **Whole Woman's Health**
Complication Log
Month of November Start Date (this page): 01 End Date (this page): 30

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials

[redacted]

No Complications

[LOGO] **Whole Woman's Health**

Complication Log

Month of December Start Date (this page): 01 End Date (this page): 31

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
12/28/13	Redacted	11/23/13	Passing clots, bleeding x 2 wks	Cytotec Buccally 800 mcg → 0 resolution Resuction performed 12/28/13	KA	

Whole Woman's Health **Complication Log**

Month of August 2010 Start Date (this page): 08/29/10 End Date (this page): ~~October 2010~~ 12/11

Today's Date	Patient Name	Date of TOP	Chief Complaint	Resolution	Staff Initials	Medical Director Initials
08/29/10	Redacted	8/27/10	Pulmonary Edima	Hospitalization	SQ	SW
09/10/10		9/10/10	Breast Infection	Antibiotics & follow up —Keflex —Tylenol	SQ	SW
10/26/10		10/22/10	Severe Pain (R POC)	Misoprostol 200 mg x4—buoc. resorc.	SQ	SW
12/31/11 ~~12~~		12/28/11	pain 0 relieved 2 meds	D&C—placenta removed hospitalized overnight fever—[Illegible]	CW	SW
1/18/12		1/5/12	soaking 1 pad/1 hour pains ~~relieved~~ 2 meds	post MIFE suction	CW	Errs SW
9/20/12		9/20/12	post abortion bleeding	Transferred to University Hospital	SQ	Errs SW

[LOGO] **Whole Woman's Health**

Complication Log

Month of January Start Date (this page): 1/1/13 End Date (this page): 1/31/13

Patient Label *Name/DOB/DOS MD/MR#*	**Date of TOP**	**Complication**	**Same Day Return to OR Y/N**	**Hospital Transfer Y/N**	**Resolution**	**Staff Initials**	**Medical Director Initials**
Redacted	1/9/13	Failed MIFE	N	N	suction cartilage	SQ	SW
	1/9/13	Failed MIFE	N	N	suction cartilage	SQ	SW

[LOGO] **Whole Woman's Health**
Complication Log
Month of February 2013 Start Date (this page): 2/1/13 End Date (this page): 2/28/13

Patient Label *Name/DOB/DOS MD/MR#*	**Date of TOP**	**Complication**	**Same Day Return to OR Y/N**	**Hospital Transfer Y/N**	**Resolution**	**Staff Initials**	**Medical Director Initials**
Redacted	2/16/13	Severe cramping & bleeding	~~Y~~ [R] N	~~N~~ [R] Y	Admitted to Seton Hospital in Austin, TX underwent emergency hysterectomy	SQ	SW
	2/21/13	Uncontrolled post-op cervical bleeding	~~N~~ [R] Y	Y	Pt monitored @ Mission Trails Baptist Hosp after transfer via EMS from WWH. 0 tx requested. Pt advised [illegible] complications	SQ	SW

[LOGO] **Whole Woman's Health**

Complication Log

Month of March 2013 Start Date (this page): 3/1/13 End Date (this page): 3/31/13

Patient Label *Name/DOB/DOS MD/MR#*	**Date of TOP**	**Complication**	**Same Day Return to OR Y/N**	**Hospital Transfer Y/N**	**Resolution**	**Staff Initials**	**Medical Director Initials**
Redacted	3/16/13	Abdominal pain, heavy bleeding & large clots	N	N	Pt seen in ER @ CTMC—San Marcos for stated complaints 0 tx provider. Pt to f/u @ WWH on Wed 3/27 for possible resuction.	SQ	SW
	3/16/13	Abd. pain/tenderness yellow vaginal discharge clotting	N	N	[Illegible] by MD. DX: PID [illegible] xbx given in clinic ([illegible]) & script for Doxycycline	Error *April ending	
	3/4/13	Failed MIFE (T) UCG	N	N	suction [illegible]	SQ	SW

[LOGO] **Whole Woman's Health**
Complication Log
Month of ~~March~~ April 2013 Start Date (this page): 4/1/13 End Date (this page): 4/30/13

Patient Label *Name/DOB/DOS MD/MR#*	**Date of TOP**	**Complication**	**Same Day Return to OR Y/N**	**Hospital Transfer Y/N**	**Resolution**	**Staff Initials**	**Medical Director Initials**
Redacted	3/16/13	Abd pain/tenderness yellow vaginal discharge clotting	N	N	[Illegible] by [Illegible] IM xbx given in clinic [Illegible] 250 mg & script for Doxycycline given in clinic	SQ	SW
	4/2/13	Cramping, clots s/p MIFE	N	N	SONO shows retained clots D&C performed in clinic	SQ	SW

[LOGO] **Whole Woman's Health**

Complication Log

Month of May 2013 Start Date (this page): 5/1/13 End Date (this page): 5/30/13

Patient Label *Name/DOB/DOS MD/MR#*	**Date of TOP**	**Complication**	**Same Day Return to OR Y/N**	**Hospital Transfer Y/N**	**Resolution**	**Staff Initials**	**Medical Director Initials**
Redacted	4/29/13	Retained clots cramping/ bleeding	N	N	Resuction	SQ	SW

[LOGO] **Whole Woman's Health**

Complication Log

Month of June 2013 Start Date (this page): 6/1/13 End Date (this page): 6/30/13

Patient Label *Name/DOB/DOS MD/MR#*	**Date of TOP**	**Complication**	**Same Day Return to OR Y/N**	**Hospital Transfer Y/N**	**Resolution**	**Staff Initials**	**Medical Director Initials**
Redacted	6/21/13	Failed MIFE—post suction post-op bleeding	N	Y	Transferred to Mission Hills Baptist via EMS blood products/IVf therapy	SQ	SW
Redacted	6/22/13	Swelling on hands & feet	N	N	Pt sent to ER MD notified (Spanish)	SQ	SW

[LOGO] **Whole Woman's Health**

Complication Log

Month of July 2013 Start Date (this page): 7/1/13 End Date (this page): 7/31/13

Patient Label *Name/DOB/DOS MD/MR#*		**Date of TOP**	**Complication**	**Same Day Return to OR Y/N**	**Hospital Transfer Y/N**	**Resolution**	**Staff Initials**	**Medical Director Initials**
Redacted	24.5 wks Redacted	D&E 7-27-13	Post-op Hemmorhage	N/A	Yes	Transported to Methodist Metro Downtown Hospital —Uterine artery embolization —Replacement of ACBCs & platelets —Pt in ICU	SQ	SW

[LOGO] **Whole Woman's Health**

Complication Log

Month of August 2013 Start Date (this page): 8/1/13 End Date (this page): 8/31/13

Patient Label *Name/DOB/DOS MD/MR#*	**Date of TOP**	**Complication**	**Same Day Return to OR Y/N**	**Hospital Transfer Y/N**	**Resolution**	**Staff Initials**	**Medical Director Initials**
		No Complications Noted				SQ	

[LOGO] **Whole Woman's Health**

Complication Log

Month of September 2013 Start Date (this page): 9/1/13 End Date (this page): 9/30/13

Patient Label *Name/DOB/DOS MD/MR#*	**Date of TOP**	**Complication**	**Same Day Return to OR Y/N**	**Hospital Transfer Y/N**	**Resolution**	**Staff Initials**	**Medical Director Initials**
		No Complications Noted				SQ	

[LOGO] **Whole Woman's Health**
Complication Log
Month of October 2013 Start Date (this page): 10/1/13 End Date (this page): 10/31/13

Patient Label *Name/DOB/DOS MD/MR#*	**Date of TOP**	**Complication**	**Same Day Return to OR Y/N**	**Hospital Transfer Y/N**	**Resolution**	**Staff Initials**	**Medical Director Initials**
		0 Complications Noted [Illegible]				SQ	

[LOGO] **Whole Woman's Health**

Complication Log

Month of November Start Date (this page): Nov 1 2013 End Date (this page): 11/30/13

Patient Label *Name/DOB/DOS MD/MR#*	**Date of TOP**	**Complication**	**Same Day Return to OR Y/N**	**Hospital Transfer Y/N**	**Resolution**	**Staff Initials**	**Medical Director Initials**

[LOGO] **Whole Woman's Health**
Complication Log
Month of December 2013 Start Date (this page): 12/1/13 End Date (this page): 12/31/13

Patient Label *Name/DOB/DOS MD/MR#*	**Date of TOP**	**Complication**	**Same Day Return to OR Y/N**	**Hospital Transfer Y/N**	**Resolution**	**Staff Initials**	**Medical Director Initials**

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS (AUSTIN)

(Admitted Aug. 4, 2014)

DEFENDANT'S
EXHIBIT
44
A 14 CV 284LY

[LOGO] TEXAS
Department of
State Health Services

Table 33 Selected Characteristics of Induced Terminations of Pregnancy Texas Residence

Table 33
Selected Characteristics of Induced
Terminations of Pregnancy
Texas Residences, 2009

TOTAL NUMBER REPORTED IN TEXAS*	77,850
Out of State/Country Residents	2,526
Total Texas Residents	74,835
Not Stated	489

AGE	
11 Years or Less	0
12-13 Years	53
14-15 Years	575
16-17 Years	2,353
18-19 Years	6,365
20-24 Years	24,964
25-29 Years	19,409
30-34 Years	11,339

35-39 Years	6,814
40 Years and Over	2,600
Not Stated	363

RACE	
Asian	3,184
Hispanic	28,327
White	23,595
Black	18,570
Native American	139
Other	534
Not Stated	486

MARITAL STATUS	
Married	12,764
Not Married	61,938
Not Stated	133

FACILITY OF OCCURRENCE	
Abortion Clinic	69,861
Ambulatory Surgical Center	4,531
Hospital	183
Physician's	40
Out of State	220

WEEKS OF GESTATION	
8 Weeks or Less	54,886
9-10 Weeks	9,533
11-21 Weeks	4,853
13-14 Weeks	3,014
15-16 Weeks	1,394
17-20 Weeks	682

21-25 Weeks	429
26 Weeks or More	7
Not Stated	37

TYPE OF PROCEDURE	
Suction Curettage	55,570
Medical (Non Surg.)	15,108
Dilation and Evacuation	4,069
Intra-Uterine	4
Sharp Curettage (D&C)	28
Hysterotomy/Hysterectomy	2
Other	54
Not Stated	

PREVIOUS LIVE BIRTHS	
None	27,895
One	20,032
Two	16,064
Three	7,036
Four	2,556
Five or more	1,182
Not Stated	70

PREVIOUS INDUCED ABORTIONS	
None	42,472
One	19,757
Two	7,939
Three	2,839
Four	1,016
Five or More	703
Not Stated	109

PATIENT SURVIVED	
Survived	74,835
Did Not Survive	0

* Includes women residing outside of Texas.

2009 Annual Report List of Tables and References

Annual Reports for Other Years

Center for Health Statistics

Last updated December 16, 2011

[LOGO] TEXAS
Department of
State Health Services

Table 33 Selected Characteristics of Induced Terminations of Pregnancy Texas Residence

Table 33
Selected Characteristics of Induced
Terminations of Pregnancy
Texas Residences, 2010

TOTAL NUMBER REPORTED IN TEXAS*	77,592
Out of State/Country Residents	2,421
Total Texas Residents	74,959
Not Stated	212

AGE	
11 Years or Less	3
12-13 Years	49

14-15 Years	507
16-17 Years	2,109
18-19 Years	5,882
20-24 Years	24,561
25-29 Years	19,778
30-34 Years	12,105
35-39 Years	6,959
40 Years and Over	2,830
Not Stated	176

RACE	
Asian	3,345
Hispanic	28,817
White	22,651
Black	18,623
Native American	112
Other	729
Not Stated	682

MARITAL STATUS	
Married	12,671
Not Married	62,579
Not Stated	9

FACILITY OF OCCURRENCE	
Abortion Clinic	65,131
Ambulatory Surgical Center	9,457
Hospital	182
Physicians	60
Out of State	129

WEEKS OF GESTATION	
8 Weeks or Less	55,851
9-10 Weeks	9,133
11-21 Weeks	4,628
13-14 Weeks	2,943
15-16 Weeks	1,347
17-20 Weeks	649
21-25 Weeks	386
26 Weeks or More	14
Not Stated	8

TYPE OF PROCEDURE	
Suction Curettage	52,942
Medical (Non Surg.)	18,313
Dilation and Evacuation	3,631
Intra-Uterine	7
Sharp Curettage (D&C)	39
Hysterotomy/Hysterectomy	1
Other	15
Not Stated	11

PREVIOUS LIVE BIRTHS	
None	27,623
One	19,784
Two	16,205
Three	7,331
Four	2,706
Five or more	1,282
Not Stated	28

PREVIOUS INDUCED ABORTIONS	
None	41,858
One	20,277
Two	8,140
Three	2,715
Four	1,110
Five or More	810
Not Stated	49

PATIENT SURVIVED	
Survived	74,959
Did Not Survive	0

* Includes women residing outside of Texas.

2010 Annual Report List of Tables and References

Annual Reports for Other Years

Center for Health Statistics

Last updated June 08, 2012

[LOGO] TEXAS
Department of
State Health Services

Table 33 Selected Characteristics of Induced Terminations of Pregnancy Texas Residence

Table 33
Selected Characteristics of Induced
Terminations of Pregnancy
Texas Residences, 2011

TOTAL NUMBER REPORTED IN TEXAS*	72,470
Out of State/Country Residents	2,240
Total Texas Residents	70,003
Not Stated	227

AGE	
11 Years or Less	0
12-13 Years	43
14-15 Years	485
16-17 Years	1,798
18-19 Years	5,171
20-24 Years	22,561
25-29 Years	18,480
30-34 Years	11,722
35-39 Years	6,611
40 Years and Over	2,955
Not Stated	177

RACE	
Asian	3,110
Hispanic	26,392

White	21,645
Black	17,336
Native American	124
Other	721
Not Stated	675

MARITAL STATUS	
Married	11,474
Not Married	58,521
Not Stated	8

FACILITY OF OCCURRENCE	
Abortion Clinic	53,799
Ambulatory Surgical Center	15,853
Hospital	178
Physicians	35
Out of State	138

WEEKS OF GESTATION	
8 Weeks or Less	52,062
9-10 Weeks	8,310
11-21 Weeks	4,514
13-14 Weeks	2,758
15-16 Weeks	1,254
17-20 Weeks	723
21-25 Weeks	351
26 Weeks or More	23
Not Stated	8

TYPE OF PROCEDURE	
Suction Curettage	47,520
Medical (Non Surg.)	18,164
Dilation and Evacuation	4,233
Intra-Uterine	4

Sharp Curettage (D&C)	20
Hysterotomy/Hysterectomy	4
Other	58
Not Stated	0

PREVIOUS LIVE BIRTHS	
None	25,996
One	18,473
Two	14,824
Three	6,858
Four	2,538
Five or more	1,286
Not Stated	28

PREVIOUS INDUCED ABORTIONS	
None	39,574
One	18,587
Two	7,551
Three	2,552
Four	974
Five or More	707
Not Stated	58

PATIENT SURVIVED	
Survived	70,003
Did Not Survive	0

* Includes women residing outside of Texas.

2011 Annual Report List of Tables and References

Annual Reports for Other Years

Center for Health Statistics

Last updated March 29, 2013

LOGO] TEXAS
Department of
State Health Services

Table 33 Selected Characteristics of Induced Terminations of Pregnancy Texas Residence

Table 33
Selected Characteristics of Induced
Terminations of Pregnancy
Texas Residences, 2012

TOTAL NUMBER REPORTED IN TEXAS*	68,298
Out of State/Country Residents	2,056
Total Texas Residents	66,098
Not Stated	144

AGE	
11 Years or Less	0
12-13 Years	25
14-15 Years	411
16-17 Years	1,475
18-19 Years	4,362
20-24 Years	21,047
25-29 Years	17,891
30-34 Years	11,573
35-39 Years	6,362
40 Years and Over	2,769
Not Stated	183

RACE	
Asian	3,023
Hispanic	24,800

White	19,986
Black	16,545
Native American	104
Other	1,030
Not Stated	610

MARITAL STATUS	
Married	10,365
Not Married	55,714
Not Stated	19

FACILITY OF OCCURRENCE	
Abortion Clinic	51,740
Ambulatory Surgical Center	14,016
Hospital	202
Physicians	43
Out of State	97

WEEKS OF GESTATION	
8 Weeks or Less	48,377
9-10 Weeks	8,062
11-21 Weeks	4,443
13-14 Weeks	2,723
15-16 Weeks	1,362
17-20 Weeks	766
21-25 Weeks	342
26 Weeks or More	11
Not Stated	12

TYPE OF PROCEDURE	
Suction Curettage	43,327
Medical (Non Surg.)	18,335

Dilation and Evacuation	4,339
Intra-Uterine	3
Sharp Curettage (D&C)	59
Hysterotomy/Hysterectomy	4
Other	23
Not Stated	8

PREVIOUS LIVE BIRTHS	
None	24,538
One	17,209
Two	13,975
Three	6,632
Four	2,455
Five or more	1,253
Not Stated	36

PREVIOUS INDUCED ABORTIONS	
None	37,431
One	17,847
Two	6,836
Three	2,392
Four	832
Five or More	698
Not Stated	62

PATIENT SURVIVED	
Survived	66,098
Did Not Survive	0

* Includes women residing outside of Texas.

2012 Annual Report List of Tables and References

Annual Reports for Other Years

Center for Health Statistics

Last updated June 26, 2014

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH; *et al.*, Plaintiffs,	)	CIVIL ACTION
v.	)	CASE NO. 14-CV-284-LY
DAVID LAKEY, M.D.; *et al.*, Defendants.	)	

DIRECT TESTIMONY OF
AMY HAGSTROM MILLER

(Filed Aug. 5, 2014)

AMY HAGSTROM MILLER under penalty of perjury, testifies as follows:

1. I am the founder, President and CEO of Whole Woman's Health, which has been providing high-quality reproductive health care services, including abortion services, to Texas women for over a decade. We currently operate licensed abortion facilities in Fort Worth and San Antonio. In addition, we operate a licensed ASC in San Antonio. Until recently, Whole Woman's Health also operated licensed abortion facilities in Austin, Beaumont, and McAllen (the "McAllen clinic"). These facilities closed as a result of Texas House Bill No. 2—in particular, as a result of the "admitting privileges requirement," which mandates that all physicians who provide abortion services "have active admitting privileges at a hospital

that is located not further than 30 miles from the location at which the abortion is performed or induced," and the "ASC requirement," which mandates that "the minimum standards for an abortion facility must be equivalent to the minimum standards for ambulatory surgical centers" under Texas law.

2. Whole Woman's Health is a member of the National Abortion Federation ("NAF"). All of our medical facilities therefore comply with NAF's Clinical Policy Guidelines.

The McAllen Clinic

3. The McAllen clinic provided a range of reproductive health care services, including abortion services, to women in the Rio Grande Valley. After October 31, 2013, the McAllen clinic was forced to stop providing abortion services as a result of the admitting privileges requirement. It continued to provide non-abortion services such as pregnancy testing, ultrasound, and contraceptive counseling for another four months, while operating at a substantial loss, but ultimately, it was forced to cease operations altogether on March 6, 2014. Nevertheless, Whole Woman's Health remains in possession of the McAllen clinic's building and abortion facility license, and we intend to reopen the clinic if we obtain a favorable decision from the Court.

4. Whole Woman's Health first began operating the McAllen clinic in January 2004. It has been licensed by the Texas Department of State Health

Services ("DSHS") to provide abortion services since that time.

5. Prior to the admitting privileges requirement taking effect, Texas law limited the provision of surgical abortion in a facility like ours to 16 weeks of pregnancy, and we adhered to that limit at the McAllen clinic. Texas law now limits the provision of medication abortion to five weeks of pregnancy. If the McAllen clinic were to resume providing services, we would adhere to that requirement.

6. The highest level of sedation offered to patients at the McAllen clinic was moderate sedation/analgesia, also known as conscious sedation. We did not use deep sedation or general anesthesia.

7. The McAllen clinic had an outstanding safety record. During the past ten years, we provided abortion services to over 14,000 women at the McAllen clinic. Few patients experienced serious complications from an abortion procedure and only two patients required transfer from the clinic to a hospital. In both of those cases, the patients were successfully treated at the hospital.

Inability to Comply with the Admitting Privileges Requirement

8. After the admitting privileges requirement was enacted, four physicians who provide abortion services for Whole Woman's Health sought to obtain admitting privileges at a hospital within 30 miles of

the McAllen clinic, but each was ultimately unable to do so. All four physicians are board-certified obstetrician-gynecologists with years of experience performing abortion procedures. Three of them have admitting privileges at hospitals in other parts of the State.

9. To assist these physicians in obtaining the required admitting privileges, my staff conducted research to identify all of the hospitals within 30 miles of the McAllen clinic. We determined that there are eight such hospitals, seven of which provide obstetric or gynecological services: Rio Grande Regional Hospital, Mission Regional Medical Center, Doctors Hospital at Renaissance, and four hospitals affiliated with the South Texas Health System.

10. We then contacted the hospitals to determine the procedures and requirements for obtaining admitted privileges. All seven McAllen-area hospitals require, as a condition of granting admitting privileges, that an application be signed by a "designated alternate" physician willing to attend to the applicant's patients when the applicant is unavailable. The designated alternate physician must already have admitting privileges at the hospital. If an application is not signed by a designated alternate physician, it will not be considered, regardless of whether the applicant meets the hospital's other criteria.

11. My staff and I reached out to numerous physicians in the McAllen area about serving as the required designated alternate physician. Only one

physician, who had admitting privileges at Doctors Hospital at Renaissance, was willing to do so. The others expressed concern about retaliation from the hospitals at which they had admitting privileges and the possibility that their privileges would be revoked or discontinued if they facilitated the application of an abortion provider.

12. Thus, our physicians were only able to satisfy the designated alternate physician requirement for one hospital within 30 miles of the McAllen clinic: Doctors Hospital at Renaissance.

13. The first step in applying for admitting privileges at Doctors Hospital at Renaissance is to send a letter requesting an application for admitting privileges. In September 2013, each of the four physicians submitted requests.

14. Subsequently, each of the physicians received a letter in response from the hospital stating that his or her request for an application had been denied. In particular, each letter stated that, based on the recommendation of the hospital's Credentials Committee, the Medical Executive Committee was denying the physician's request for an application for privileges. Each letter further stated that the Board of Governors had considered the request and determined not to extend an application, "as authorized under the Bylaws and Rules and Regulations of the Medical Staff for the Hospital" and that the "decision of the Governing Board was not based on clinical competence consideration." The letters provided no

other explanation for why each of the four physicians were being denied the opportunity to apply for admitting privileges at the hospital. The letters are being offered collectively as Plaintiffs' trial exhibit P-068.

15. Despite extensive efforts, Whole Woman's Health has been unsuccessful in recruiting physicians who already possess admitting privileges at a hospital within 30 miles of the McAllen clinic to provide abortion services at the clinic. We engaged in direct recruitment of physicians, posted job listings on listservs maintained by reproductive health organizations, and utilized professional networks to spread the word.

16. Physicians have cited several reasons for declining recruitment offers from Whole Woman's Health: Many are worried about their personal safety and the safety of their families. Harassment and threats of violence have been a particular problem at the McAllen clinic, leading to a recent investigation by the Federal Bureau of Investigation and Department of Justice. In addition, some physicians are concerned about the hostile regulatory environment in Texas and potential exposure to criminal liability. Some also express concern about retaliation by hospital administrators and other medical professionals who are opposed to abortion.

Impact of Clinic Closures on Women in the Rio Grande Valley

17. Following the closure of the McAllen clinic, women now have to travel outside the region to obtain legal abortion care, but many lack the resources to do so or face obstacles that are too substantial to overcome.

18. During the four-month period of time when the McAllen clinic was open but not providing abortion services, Whole Woman's Health worked with a nonprofit organization to provide financial assistance in the form or gas cards and bus tickets to women who presented at the clinic seeking abortion services. The purpose was to enable patients to travel to a licensed abortion facility in San Antonio. The vast majority of women, however, would not accept the assistance because other obstacles prevented them from making the trip to San Antonio. These obstacles included the inability to take the required length of time off from work and the inability to secure childcare for that length of time. Many women also reported having an immigration status that permitted them to be present in the region of the United States bordering Mexico, but did not permit them to travel north of Falfurrias.

19. During this period of time, staff at the McAllen clinic saw a significant increase in women who had attempted self-abortion through various methods, including using medication obtained over the Internet, on the black market, or over the border

in Mexico. The staff also encountered women who had attempted to use herbal teas, douches, or non-coerced physical abuse to their pelvic region to attempt to induce an abortion.

Inability to Comply with the ASC Requirement

20. The license for our Austin clinic was set to expire at the end of last month. We did not renew it because we would not have been able to provide abortion services there after the ASC law took effect. Accordingly, that facility is now closed. If we prevail in this lawsuit, however, we would reestablish a licensed abortion facility in Austin.

21. We also operate facilities in Ft. Worth and San Antonio that do not meet ASC construction standards. These facilities will have to close by September 1, 2014, if the ASC requirement is not enjoined.

22. Furthermore, the McAllen clinic does not meet ASC construction standards. Even if one of our doctors was able to obtain admitting privileges at a McAllen-area hospital, we would not be able to reopen the clinic after the ASC requirement takes effect.

23. We have made a variety of efforts over the past year to lease or purchase an ASC facility. All of these efforts proved fruitless. An ASC available for lease in Austin seemed promising, but it turned out that a restrictive covenant runs with the property that prohibits its use for "sterilization procedures,

abortions, or the promotion of such activities." A copy of this covenant is being offered as Plaintiffs' Trial Exhibit P-066. An ASC available for purchase in Ft. Worth also seemed promising. But the property is appraised for $ 2.3 million, and to date, we have been unable to obtain financing for the purchase.

24. Absent relief from the Court, on September 1, 2014, all of the remaining facilities operated by Whole Woman's Health except one—our ASC in San Antonio—will be forced to close. This will cause a dramatic reduction in access to abortion services for women throughout Texas.

Dated: August 3, 2014
Austin, Texas

By: /s/ Amy Hagstrom Miller
Amy Hagstrom Miller

Supreme Court, U.S.
FILED
DEC 2 0 2015
OFFICE OF THE CLERK

No. 15-274

In The Supreme Court of the United States

WHOLE WOMAN'S HEALTH ET AL. PETITIONERS

v.

KIRK COLE, M.D., COMMISSIONER OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

JOINT APPENDIX VOLUME V

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH; *et al.*,	)	
Plaintiffs,	)	CIVIL ACTION
v.	)	CASE NO. 14-CV-284-LY
DAVID LAKEY, M.D.; *et al.*,	)	
Defendants.	)	

DIRECT TESTIMONY OF MARILYN ELDRIDGE

(Filed Aug. 5, 2014)

MARILYN ELDRIDGE, under penalty of perjury, testifies as follows:

1. I am the President of Nova Health Systems, Inc. d/b/a Reproductive Services ("Reproductive Services"), a not-for-profit Texas charitable corporation whose mission is to provide high-quality and affordable reproductive health care services, including abortion services, to women in underserved communities.

2. Founded in 1973 by a Christian minister, Reproductive Services has operated a total of ten medical clinics in three states. Currently, Reproductive Services operates a clinic in Tulsa, Oklahoma, and until April 2014, we operated a clinic in El Paso, Texas (the "El Paso Clinic"). We opened the first independent abortion clinic in the State of Texas following the Supreme Court's 1973 decision in *Roe v.*

Wade, and we operated continuously in the State until the closure of our El Paso clinic earlier this year.

3. In 1987, the principals of Reproductive Services founded a nonprofit organization called Adoption Affiliates, whose mission is to make professional, nonjudgmental adoption services available to women with unintended pregnancies. Reproductive Services and Adoption Affiliates have interlocking boards of directors. All of Reproductive Services' medical clinics, including the El Paso clinic, have had Adoption Affiliates' employees working on-site.

4. I am familiar with the requirements of Texas House Bill No. 2 (HB2), including the "admitting privileges requirement," which mandates that all physicians who provide abortion services "have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced," and the "ASC requirement," which mandates that "the minimum standards for an abortion facility must be equivalent to the minimum standards for ambulatory surgical centers" under Texas law.

Services Provided at the El Paso Clinic

5. The El Paso clinic operated continuously from 1977 until earlier this year, and had been licensed as an abortion facility by the State of Texas. It was a member of the National Abortion Federation ("NAF").

6. The El Paso clinic provided a variety of gynecological and family planning services to women in West Texas, including surgical and medical abortion; well-woman examinations, comprised of pelvic examinations, pap smears, and breast examinations; diagnosis and treatment of sexually transmitted infections, provision of contraceptives, and pregnancy testing. In addition, as stated above, we worked with Adoption Affiliates to help interested women place their children for adoption.

7 We also offered surgical abortion and medical abortion services. The highest level of sedation offered to surgical abortion patients was minimal sedation. We did not use moderate sedation, deep sedation, or general anesthesia No form of sedation or anesthesia is needed or offered in connection with medical abortion. Reproductive Services is a member of the National Abortion Federation ("NAF"). As a result, its clinics comply with NAF's Clinical Policy Guidelines.

Qualifications of the Medical Director

8. The Medical Director of the El Paso Clinic was Dr. Pamela Richter, who served in that role for over twenty years. Dr. Richter is a board-eligible family medicine physician licensed to practice medicine by the State of Texas. She graduated from the Texas College of Osteopathic Medicine in 1983, then completed an internship at the Corpus Christi Osteopathic Hospital.

9. Dr. Richter is a warm and caring physician with an excellent bedside manner. For more than two decades, she provided outstanding care to the patients at the El Paso clinic.

10. In addition, Dr. Richter works for the State of Texas. She serves as a staff physician for the state supported living center ("State Center") in El Paso operated by the Texas Department of Aging and Disability Services ("DADS"). There, she provides general medical care and gynecological services to people with intellectual and developmental disabilities who are medically fragile or have behavioral problems. The State Center provides 24-hour residential services, comprehensive behavioral treatment services, vocational and rehabilitation services, and general health care services. The El Paso campus occupies 20 acres and is home to approximately 117 people.

11. Previously, from 1990 to 2001, Dr. Richter maintained a private family medicine practice in El Paso.

12. From 1990 to 2009, she was board certified in family medicine. She did not seek recertification after 2009 because the nature of her practice did not require board certification.

13. I understand that, beginning in 1990, Dr. Richter held admitting privileges at one or both of the hospitals in the Las Palmas del Sol hospital system for ten years. She resigned from the hospital staff in June 2000 because, at that point, the nature of her practice did not require her to admit patients to the

hospital and she was having difficulty satisfying the hospital's minimum patient contact requirement and holding emergency room call as frequently as the hospital required. Her letter of resignation from Las Palmas Medical Center is being offered as Plaintiffs' trial exhibit P-056.

Efforts to Comply with the Admitting Privileges Requirement

14. Dr. Richter is the only physician who provided abortion services at the El Paso clinic.

15. After passage of the admitting privileges requirement, Dr. Richter sought to obtain admitting privileges at a hospital within 30 miles of the El Paso clinic. The Administrator of the El Paso clinic assisted her with this process.

16. They identified four hospital groups within a 30-mile radius of the clinic: Las Palmas del Sol ("Las Palmas"), which includes two qualifying hospitals, Las Palmas Medical Center and Del Sol Medical Center; University Medical Center of El Paso ("UMC"); Sierra Providence Health Network ("Sierra Providence"), which includes three qualifying hospitals, Providence Memorial Hospital, Sierra Medical Center, and Sierra Providence East Medical Center; and Foundation Surgical Hospital of El Paso ("Foundation").

17 To date, Dr. Richter has been unable to secure permanent admitting privileges at any of these hospitals.

18. After submitting her application for admitting privileges at the Las Palmas hospitals, she was informed that her application would not be considered unless she provided documentation of board-certification, which she cannot do presently.

19. We received the same information from UMC, although her application there remains pending as we work with the hospital to explore other ways to demonstrate her qualifications.

20. After submitting an application to Foundation, Dr. Richter was granted temporary privileges for 120 days beginning on January 13, 2014. The instrument granting those privileges is being offered by Plaintiffs' as a trial exhibit (P-030).

21. Subsequently, Foundation informed us by letter dated February 12, 2014, that Dr. Richter's application for permanent privileges was being denied. The letter stated that "it is the decision of the Governing Body to deny your application for the reason that you do not meet requirement [sic] for successfully completing a residency in the field of specialty for which clinical privileges are required." This letter is being offered as Plaintiffs' trial exhibit P-060. This was curious because the application form for family medicine privileges at this hospital indicates that completion of a family medicine residency is not required if the physician can demonstrate

"active participation in the examination process leading to certification in family practice. " This application form is being offered as Plaintiffs' trial exhibit P-062. In fact, Dr. Richter has registered to take the board examination for family medicine in November 2014, which is the next available testing period.

22. In April 2014, Reproductive Services was informed through its attorney that Foundation Hospital would no longer honor Dr. Richter's temporary privileges.

23. Dr. Richter did not submit an application for admitting privileges to the Sierra Providence hospitals because the Administrator of the El Paso clinic was informed by phone that she would not be eligible for privileges there until she became board certified again.

24. I am concerned that, even if Dr. Richter ultimately obtains permanent admitting privileges at one of these hospitals, she would not be able to maintain those privileges because she will not be able to admit the requisite number of patients per year to the hospital. During the past 10 years, over 17,000 abortion procedures were performed at the El Paso clinic. Not a single one of those patients had to be transferred to a hospital for emergency treatment, much less admitted to the hospital.

25. Reproductive Services has sought to recruit additional physicians to provide abortion services at the El Paso clinic, but has not succeeded in doing so.

There is a lot of hostility toward abortion in Texas, and many physicians fear that providing abortion services would trigger retaliation against themselves or their family members.

Closure of the El Paso Clinic

26. In April of this year, after learning that Foundation Hospital would no longer honor Dr. Richter's temporary admitting privileges, the El Paso was forced to cease providing abortion services. It closed completely on June 1, 2014, after 37 years of continuous service to the women of West Texas.

27 If we are successful in this lawsuit, however, Reproductive Services would seek to reestablish a licensed abortion facility in El Paso.

The El Paso Clinic's Medical Emergency Protocol

28. Prior to its closure, the El Paso clinic maintained a protocol for responding to medical emergencies that had been approved by the Texas Department of State Health Services and that served to ensure patient safety and continuity of care in the event of a medical emergency requiring a hospital transfer. In addition, Dr. Richter maintained an agreement with a backup physician who has admitting privileges at a local hospital.

29. Nevertheless, as I stated earlier, during the past ten years, there was not a single medical

emergency at the El Paso clinic requiring a hospital transfer.

Characteristics of the Patients Served by the El Paso Clinic

30. Some of our patients lived or worked at one of the three military bases in the El Paso region; the patients from the military bases tended to be more ethnically diverse and socioeconomically advantaged than our patient population as a whole. Most of our patients were poor; most were Latina; and most were single mothers.

31. Every month, approximately two or three patients disclosed that they attempted to self-induce an abortion by ingesting what they believed to be misoprostol, but they remained pregnant.

32. The El Paso clinic was located just a short distance from the Mexican border, where misoprostol is widely available.

Impact of the ASC Requirement

33. The El Paso clinic was not an ambulatory surgery center ("ASC"), and the cost of operating an ASC would make abortion care prohibitively expensive for Reproductive Services' patients, many of whom are living in poverty.

34. The only other abortion facility west of San Antonio that is operated by the State of Texas is the

Hilltop Women's Reproductive Clinic in El Paso. I understand that this clinic does not meet the minimum standards for ASCs under Texas law and will close before September.

35. At that point, for women in West Texas, the nearest Texas facility providing abortion care would be in San Antonio. The distance from El Paso to San Antonio is over 550 miles.

36. I am deeply concerned that, with the closure of both licensed abortion clinics in El Paso, many women will be unable to access legal abortion care and will attempt self-abortion.

Dated: August 3, 2014
Austin, Texas

By: /s/ Marilyn Eldridge
Marilyn Eldridge

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH, ABORTION ADVANTAGE, AUSTIN WOMAN'S HEALTH CENTER, KILLEEN WOMAN'S HEALTH CENTER, NOVA HEALTH SYSTEMS, SHERWOOD C. LYNN, JR. M.D., PAMELA J. RICHTER D.O., LENDOL L. DAVIS M.D.,	AU:14-CV-00284-LY
VS.	
DAVID LAKEY M.D., MARI ROBINSON.	AUSTIN, TEXAS AUGUST 5, 2014

****

TRANSCRIPT OF BENCH TRIAL
BEFORE THE HONORABLE LEE YEAKEL

VOLUME 2 OF 5

****

* * *

[4] **MARILYN ELDRIDGE,**

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. TOTI:

Q. Good morning, Ms. Eldridge.

A. Good morning.

Q. Could you please state your full name for the record.

A. Yes. My name is Marilyn Eldridge.

Q. Ms. Eldridge, have you submitted a trial declaration in this case?

A. Yes, I have.

Q. And does that trial declaration contain a complete and accurate statement of the testimony that you wish to offer?

A. Yes, it does.

Q. Thank you very much.

MS. TOTI: Your Honor, at this point Plaintiffs move for the admission of the trial declaration of Marilyn Eldridge.

THE COURT: Any objection?

MR. STEPHENS: Yes, Your Honor. The State objects on hearsay grounds to paragraphs 22, 23, and 25 of the direct [5] testimony submitted.

THE COURT: All right. I will hold the objection and allow you to explore whether there is an exception to hearsay rule when you cross-examine Ms. Eldridge, and you may renew your objection at that time.

MR. STEPHENS: Okay. Thank you, Your Honor.

THE COURT: And I can't resist this. You-all don't have to thank me for my rulings. The taxpayers of this country pay me to make those rulings. I don't need additional thanks. It's appreciated but unnecessary. The witness was passed.

MR. STEPHENS: Okay.

THE COURT: I will admit subject to the renewal of the objections the declaration entitled Direct Testimony of Maryland Eldridge.

CROSS-EXAMINATION

BY MR. STEPHENS:

Q. Good morning, Ms. Eldridge.

A. Good morning.

Q. Andrew Stephens, Office of the Attorney for the State defendants.

Ms. Eldridge, you're the president of Reproductive Services; is that correct?

A. Yes. That's correct.

Q. And Reproductive Services is one of the plaintiffs in this lawsuit; is that right?

[6] A. Actually, it's Nova Health Systems, but we do business as Reproductive Services.

Q. Right. So if I refer to Reproductive Services, you'll understand that I'm referring to Nova Health Systems, d/b/a Reproductive Services?

A. Yes, I do.

Q. And is there a board for Reproductive Services?

A. Yes, there is.

Q. And is Dr. Alan Braid a member of that board?

A. Yes, he is.

Q. And you had a deposition in this case; is that right?

A. That's right.

Q. And Mr. Soto took your deposition?

A. Yes, he did.

Q. Do you know whether Dr. Braid plans to open an ambulatory surgical center to offer abortion services in San Antonio, Texas?

A. Yes. I believe that he does. He's not had an easy time so far, but he hopes to be able to do so.

Q. Okay. And do you also know that he plans to open that ambulatory surgical center with Dr. Eduardo Aquino?

A. They are currently partners, and I believe so.

Q. Right. And Dr. Aquino was the owner of the abortion clinic that previously was open in Corpus Christi, Texas; is that right?

[7] A. Yes.

Q. And that clinic has since closed – the Corpus Christi clinic has since closed?

A. Yes, it has.

Q. And so now Dr. Aquino and Dr. Braid are planning to open the ambulatory surgical center in San Antonio?

A. They hope to be able to do so, yes.

Q. Okay. I believe you also testified at your deposition that Reproductive Services has considered the possibility of opening an abortion clinic in the El Paso area on the New Mexico side of the border; is that right?

A. Well, it was considered, yes. That's correct.

Q. Okay. And is that still considered a possibility for Reproductive Services?

A. Not at this time. We are Texans, and we would like to be able to stay in Texas.

Q. Okay. So your testimony at your deposition that Reproductive Services was considering that possibility, it's now your testimony that that's not the case?

A. Well, there's certainly – the Board is in charge of what we do and gives direction to me. At this time they do not seem particularly interested in New Mexico.

Q. Okay. In your direct testimony submitted in this case – and I'm going to refer to what I've marked as paragraph 13 – which states that, "I understand that, beginning in 1990, [8] Dr. Richter held admitting privileges at one or both of the hospitals in the Las Palmas Del Sol Hospital System for 10 years." Is the Las Palmas Del Sol Hospital System in El Paso area?

A. Yes, it is.

Q. Okay. And your testimony continues, "She resigned from the hospital staff in June 2000 because, at that point, the nature of her practice did not require her to admit patients to the hospital." Is that correct?

A. That is correct.

Q. Do you know what the nature of Dr. Richter's practice was from 2001 to 2005?

A. 2001 to 2005?

Q. Yes.

A. Well, she certainly had been a family medicine physician, and she worked for Reproductive Services. And there was no need to admit patients to hospitals at that time, so I don't really understand your question.

Q. Okay. Do you – do we have a copy of the binder – exhibit binder?

MR. STEPHENS: May I approach, Your Honor? Oh. I'm not supposed to ask.

THE COURT: Well, it wasn't a question that you're not supposed to ask. You don't have to ask.

MR. STEPHENS: Okay.

[9] THE COURT: It's not a prohibition.

Q. (BY MR. STEPHENS) Ms. Eldridge, I'd like to refer you to Defendants' Exhibit 18, which is in the binder. It's marked as D-18. And could you describe this document?

A. Yes. It's the CV of Dr. Richter, Dr. Pam Richter.

Q. And so this is the Dr. Richter that you were referring to in your – in your direct testimony; is that right?

A. Yes, it is.

Q. And do you see under "Experience" towards the bottom of the page where it references her employment from 2001 to 2005?

A. Yes.

Q. And what was the nature of that employment at that time?

A. It was a laser hair removal clinic. Dr. Richter has always tried to serve women as they come to her, and that seemed to be a need. I don't think that she did much.

Q. And I understand. In your direct testimony today, you have also stated that, during the past 10 years, there was not a single medical emergency at the El Paso clinic requiring a hospital transfer?

A. Yes. Requiring a hospital transfer, yes. That's correct.

Q. I'd like for you to refer to D-34 in the binder, which is the Defendants' Exhibit 34. And do you recognize that document?

A. Yes, I do.

Q. And could you describe the document for the Court?

[10] A. Yes. It's a report that is of complications report, which clinics are required in Texas to send in if there are complications.

Q. Right. So Reproductive Services, if a complication were to occur, would complete that form and submit it to the Texas Department of State Health Services; is that right?

A. That's correct.

Q. And Reproductive Services complies with state law in that regard?

A. Absolutely.

Q. Okay. I'd like now to – I'd like now for you to flip to D-38, which is Defendants' Exhibit 38.

MR. STEPHENS: And, Your Honor, before we address this exhibit, Department of State Health Services has asked for clarification from the Court on the use of this document which may be confidential under Texas Health and Safety Code, Section 245. Your Honor had previously entered an order authorizing the disclosure and the use of documents protected under that statute at trial and we redacted any identifying information from this document for that purpose. And DSHS has asked for a clarification that the Court's order covers the use of this document at trial.

THE COURT: Well, exactly what is the request? If it is redacted as it goes into the record, as it appears to me on the copy that I have been provided, it does not appear to [11] violate any privacy concerns.

MR. STEPHENS: Okay. Thank you, Your Honor. That's the clarification we needed.

THE COURT: Let me inquire of the plaintiffs. Are the plaintiffs comfortable with the exhibit as redacted?

MS. TOTI: Yes, Your Honor. As redacted, it's fine.

THE COURT: All right. Then the exhibit Defendants' No. 38, which the Court has previously admitted into evidence, will remain a public document because privacy concerns have been resolved by the redacting.

MR. STEPHENS: Thank you, Your Honor.

Q. (BY MR. STEPHENS) Ms. Eldridge have you had a chance to review D-38?

A. Yes, I have.

Q. And could you describe this document.

A. Yes. It is a document that was submitted to the health department that indicated a complication from a medical abortion. Unfortunately, there's no date of the abortion, but I believe it would have been approximately two or two and a half weeks prior to this time.

Q. And what time was that?

A. Well, it's November 5th of '13 is when the complication itself presented.

Q. Okay. And could you read the summary of the complication described at the bottom of this form – of D-38?

[12] A. Yes. "Patient presented 11/4/13 with complaint of heavy bleeding four days prior. Ultrasound noted possible retained tissue and a hematocrit of 7 percent. Patient referred to ER for blood transfusion before aspiration of retained tissue could be

treated. Patient delayed going to ER until 11/5/13 in the evening – or p.m. Patient was transfused and aspiration was performed at William Beaumont Army Medical Center."

Q. And William Beaumont Army Medical Center is a hospital in El Paso, Texas?

A. Yes, it is.

MR. STEPHENS: No further questions, Your Honor.

THE COURT: Further direct?

REDIRECT EXAMINATION

BY MS. TOTI:

Q. Good morning again, Ms. Eldridge?

A. Good morning.

Q. So I believe Mr. Stephens just asked you about this patient that had gone to the emergency room at William Beaumont Army Medical Center. Do you recall those questions?

A. Yes, I do.

Q. Was William Beaumont Army medical center one of the hospitals that Reproductive Services identified as being within 30 miles of the clinic?

A. Well, it's an Army hospital, yes. Actually, no. It was not one of the four in the system because we would not [13] transport people there, if necessary.

Q. Why is that?

A. Well, it's an Army facility, and this patient self-admitted. She was an Army person in the service.

Q. To the best of your understanding, can non-Army personnel have admitting privileges at an Army hospital?

A. I don't think so.

Q. Ms. Eldridge, for how long was Dr. Richter affiliated with Reproductive Services?

A. Over 20 years.

Q. Was she a good physician?

A. She was – she was a great physician for us. She treated the whole woman. She did a beautiful job.

Q. So, Ms. Eldridge, is it your understanding that Dr. Richter at one time had admitting privileges at a hospital in the El Paso area?

A. Yes. I know that she did.

Q. And do you know approximately when she had those privileges?

A. I believe from 1990 until somewhere in 2009 or something along that – those lines.

Q. Okay. I'd like to show you a document that might refresh your recollection.

A. All right.

Q. Can you see that?

[14] A. Well, sort of, yes.

Q. Okay.

A. Thank you. That's better.

Q. So, Ms. Eldridge, what is this document?

A. This is a resignation from her – of her privileges. Yeah. If you could move it down a little bit, please. Yeah.

– of her privileges. I guess I overestimated. I think it was 2000. Rather than 2009, may I change that testimony to 2000?

Q. Of course.

A. And when she – was not admitting the requisite number of patients, her – the nature of her practice did not make that necessary and she was bogged down with ER calls. It was a small hospital. So she didn't want to have to do that also, the duties that was required.

Q. Okay. And I'll note for the record that this exhibit has been marked as Plaintiffs' 56 for identification.

And this is the – this is the letter that you reference in your direct testimony; is that correct?

A. Yes, it is.

Q. Okay. Ms. Eldridge, did Dr. Richter apply for admitting privileges at Foundation Surgical Hospital of El Paso?

A. Yes, she did.

Q. And what was the outcome of that application?

A. She was granted temporary admitting privileges in January [15] of this year for 120 days.

Q. I'm going to attempt to show you what is marked as Plaintiffs' Exhibit 30. Have you ever seen this document before?

A. Yes, I have.

Q. What is this document?

A. It is a document that grants Dr. Richter temporary admitting privileges from Foundation Hospital.

Q. And at the top it's addressed to Dr. Richter, and then the address is listed as 730 East Yandell, El Paso, Texas 79902. Are you familiar with that address?

A. I certainly am. That is the address of the clinic Reproductive Services.

THE COURT: Pardon me. What was the exhibit number?

MS. TOTI: Your Honor, it's Plaintiffs' 30.

THE COURT: What you're displaying is different from the description of Plaintiffs' 30 on the exhibit list I have, I believe. It is described on my list as the faculty guidelines institute excerpt from guidelines for design and construction of hospital and outpatient facilities.

MS. TOTI: I apologize for that, Your Honor. We'll provide the Court with an amended exhibit list.

THE COURT: But this is in fact marked Plaintiffs' 30; is that correct?

MS. TOTI: Yes. I believe that some of the exhibits [16] were withdrawn, and then we just reused the numbers.

THE COURT: All right. Let me just mention. It is helpful whenever you try a case to the judge or to the jury that you don't change the exhibit list from what we try to follow along with on the bench here if you want to have a record that is understandable to any appellate court.

MS. TOTI: Of course, Your Honor.

Q. (BY MS. TOTI) So, Ms. Eldridge, you received this document at Reproductive Services, correct?

A. Yes. At Reproductive Services. I did.

Q. And Reproductive Services – did Reproductive Services play any role in assisting Dr. Richter in the application process?

A. Yes. Our clinic administrator helped her in any way possible.

Q. Okay. Ultimately was – was Dr. Richter granted permanent admitting privileges at this hospital?

A. No. She was not, unfortunately.

Q. Was your understanding that these temporary admitting privileges were unconditional for 120 days?

A. Absolutely.

MS. TOTI: Your Honor, Plaintiffs would like to move P-30 into evidence.

MR. STEPHENS: Your Honor, State defendants would object on hearsay grounds to the extent that this is offered [17] for the truth of the matter asserted.

THE COURT: What's the purpose for which it's offered?

MS. TOTI: Your Honor, it's offered to show that Dr. Richter had temporary admitting privileges at this hospital for 120 days.

THE COURT: Well, I'm going to have to sustain the objection because it's hearsay as to this witness.

MS. TOTI: Well, Your Honor, then we'll offer it to support the witness's understanding that Dr.

Richter had temporary admitting privileges at the hospital for 120 days.

THE COURT: All right. I will admit the exhibit for that limited purpose only.

MS. TOTI: Thank you, Your Honor.

Q. (BY MS. TOTI) So now I'm going to ask you to take a look at what's marked as Plaintiffs' 62. And I hope it's Plaintiffs' 62 in everyone's binder.

THE COURT: Pardon me. What was the number again?

MS. TOTI: That's 62, Your Honor. I'll put it up on the screen in just a moment. It's a multipage. I just want the witness to be able to look at all of the pages.

Q. (BY MS. TOTI) Just let me know when you've had a chance to look at that.

A. Yes, I have.

Q. So are you familiar with this document, Ms. Eldridge?

[18] A. Yes. It was part of the credentialing packet we worked on from Foundation Hospital in El Paso.

Q. And do you know if – if this was one of the forms that Dr. Richter filled out as part of her application process?

A. Yes, she did.

Q. And Reproductive Services assisted her in that process?

A. That's correct.

MS. TOTI: Okay. Your Honor, we'd like to offer Plaintiffs' 62 into evidence.

MR. STEPHENS: Same objection, Your Honor. Hearsay.

MS. TOTI: Your Honor, it's being offered as part of the application process that the clinic filled out. Not for the truth of anything in the document, but that the document is what the clinic utilized.

THE COURT: Well, you're going to have to establish a basis and a predicate for the admission of this document through this witness. I'll allow you to ask her additional questions.

MS. TOTI: Sure.

Q. (BY MS. TOTI) Ms. Eldridge, is it your understanding that Dr. Richter applied for admitting privileges at Foundation Hospital?

A. Yes, it is.

Q. And what role did – what is your role at Reproductive Services?

[19] A. I am the president of the organization.

Q. And what role did Reproductive Services play in – if any, in Dr. Richter's application process at Foundation Hospital?

A. Well, a very supportive role, in that we assisted her in any way that we were able to. The administrator of the clinic is the specific person who did that.

Q. And did the clinic administrator request the application forms from the hospital?

A. Yes, she did.

Q. And did the clinic administrator maintain copies of those forms in the files at Reproductive Services?

A. Yes, she did.

Q. And is this one of the forms that the clinic administrator obtained from the hospital?

A. Yes, it is.

Q. And is this one of forms that the clinic administrator maintained in the files at Reproductive Services?

A. Yes, it is.

Q. And is it your understanding that Dr. Richter filled out this form and submitted it to Foundation Hospital?

A. That's correct.

MS. TOTI: Is Your Honor satisfied?

THE COURT: It's not a question of satisfying me. Mr. Stephens, do you have objection to the form.

MR. STEPHENS: Yes, Your Honor. To the extent the [20] testimony is that this is the form filled out by Dr. Richter, we would object on hearsay grounds.

THE COURT: Well, the parts that might have been filed out for Dr. Richter or by Dr. Richter are not subject to objection at this point because they're not in front of me. Do you have objection to this exhibit, Plaintiffs' Number 62, as it is?

MR. STEPHENS: No, Your Honor.

THE COURT: All right. Plaintiffs' Exhibit Number 62 is admitted.

MS. TOTI: Thank you, Your Honor.

Q. (BY MS. TOTI) Okay. Ms. Eldridge, I believe you told me that you thought Dr. Richter was a good physician?

A. Yes, I did.

Q. Can you tell me a little bit about the kind of relationship she had with the patients at Reproductive Services?

A. Yes. It was very much as a family practice friend would be to the patient. She was absolutely warm and caring, very interested in patients, very interested in helping women do whatever was necessary

to make their lives better or livable for them. Just a very, very caring person in every respect, who cared deeply and really wanted her patients to – to be well and do well.

Q. Ms. Eldridge, can you tell me a little bit about your [21] background? What is your educational background?

A. I have a BA in the Latin American Institute from the University of Texas here in Austin and an LLB from the University of Texas School of Law.

Q. When did you graduate from law school?

A. 1963.

Q. How many women were in your graduating class?

A. Five.

Q. Did you ever practice law?

A. No. I wanted to, but I was – well, I was told that women were not hired at that time and that I would be welcome to sit in the secretarial pool.

Q. And you did not wish to – to sit in the secretarial pool?

A. No. Well, I wound up with something sort of like that, but that was not my wish, no. Certainly not.

Q. How did you come to be in the field of reproductive health?

A. Well, in maybe a couple of ways. My parents—my father was a physician. My mother was an operating room nurse. It was part of my life growing up, and I had an opportunity to work as a volunteer for Planned Parenthood. And they were at that time in the '60s were providing wonderful services as they do today, and it was just an opportunity to—to be in the middle of helping women.

Q. And earlier in your direct testimony, you stated that [22] Reproductive Services was founded in 1973 by a Christian minister; is that correct?

A. That's correct.

Q. Who was that?

A. It was Myron Chrisman.

Q. And what was your relationship with Mr. Chrisman?

A. We were married. He was my husband.

Q. Were you—did you play a role in the founding of Reproductive Services?

A. I did. I was the chair of the task force. We were studying for over a year in the early '70s—'72, and—actually, part of '71 and '72 to see how we would react and what we might do to help women depending on what happened with *Roe v. Wade*. And so, sure enough, at the end, when *Roe v. Wade* was ruled, we were able to open the first nonprofit outpatient facility in the State of Texas on March 6th of 1973.

Q. And you said that Reproductive Services operates as a nonprofit organization?

A. Nonprofit charitable, yes. With a mission to assist women and families as they make significant decisions about their reproductive lives and providing the service to make that wish be a reality, including abortion services.

Q. Do you think it's important that those services be available to women in Texas?

A. Absolutely.

[23] Q. And why is that?

A. Well, if we – if women and families are not in control of their reproductive lives, then there's really no control at all. And we don't want to have to leave Texas, we've now been forced to do.

Q. In your testimony you also mentioned an organization called Adoption Affiliates; is that correct?

A. Yes, it is. Adoption Affiliates is our affiliate – affiliated adoption child placing agency. We have interlocking boards. And we started this organization in 1987 to – really before we had done referrals for adoption services, we found that – that we had already been furnished counseling and details and that we wanted to be able to offer the services on site rather than referring. And over the last 25, 30 years, we have – over 30 years – we have placed over 800 children in the State of Texas directly through the – our services at the clinics.

Q. So when you say you place those children, what do you mean by that?

A. We have placed them in loving homes and families here in Texas and Oklahoma.

Q. So placed children for adoption?

A. Yes. Yes.

Q. And when you said earlier that you wanted those services to be available on site, what did you mean by that?

[24] A. Well, we had people on – in the facilities, in the Reproductive Services clinics, who knew all about adoption. We had a social worker in San Antonio who immediately would go to where was necessary in terms of doing any sort of licensing requirements. We were able to serve the women there. And it was not necessarily patients, but people who came with patients and through word of mouth and people who were in the facility. And, of course, that's been harmed with being unable to operate Reproductive Services anywhere in Texas.

Q. So personnel from adoption affiliates would work on siteat the El Paso Reproductive Services Clinic; is that correct?

A. Yes. Yes. When – when necessary, surely.

MS. TOTI: Okay. Thank you. No further questions, Your Honor.

RECROSS - EXAMINATION

BY MR. STEPHENS:

Q. Ms. Eldridge, do you know why Dr. Richter was denied privileges at Foundation Surgical Hospital in El Paso in February of 2014?

A. Yes. I believe that it was because she did not have a residency from her family practice.

Q. Okay. And could you refer – could you have a look at the document that has been admitted as Defendants' Exhibit 19.

A. Yes.

Q. Have you seen this document before?

[25] A. Yes, I have.

Q. And is this the letter that Dr. Richter received stating that her privileges had been denied for the reason that she did not meet the requirement for successfully completing a residency?

A. Yes, it is.

MR. STEPHENS: No further questions, Your Honor.

THE COURT: Any further redirect?

MS. TOTI: Nothing further, Your Honor.

THE COURT: All right. You may step down.

MS. TOTI: Your Honor, the plaintiffs call Amy Hagstrom-Miller.

(Witness sworn)

AMY HAGSTROM-MILLER,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. TOTI:

Q. Good morning.

A. Good morning.

Q. Would you please state your full name for the record.

A. Amy Hagstrom-Miller.

Q. And Ms. Hagstrom-Miller, did you submit a trial declaration in this case?

A. I did.

Q. And does that declaration contain a complete and accurate [26] statement of the direct testimony that you would like to offer?

A. Yes, it does.

MS. TOTI: Your Honor, at this time we'd like to move the trial declaration of Amy Hagstrom-Miller into evidence.

MR. STEPHENS: No objection, Your Honor.

THE COURT: All right. The declaration entitled Direct Testimony of Amy Hagstrom-Miller is admitted.

MS. TOTI: Thank you, Your Honor. We pass the witness.

CROSS-EXAMINATION

BY MR. STEPHENS:

Q. Good morning, Ms. Hagstrom-Miller.

A. Good morning, Mr. Stephens.

Q. How are you today?

A. I'm fine. Thank you.

Q. Ms. Hagstrom-Miller, you're the founder, president, and CEO of Whole Woman's Health; is that correct?

A. Yes, it is.

Q. And Whole Woman's Health is a plaintiff in this lawsuit; is that right?

A. Yes.

Q. And as the president and CEO of Whole Woman's Health, you're responsible for overseeing the business and the provision of abortion services at Whole Woman's Health; is that right?

[27] A. Yes.

Q. And in your role as the president and CEO of Whole Woman's Health, you're aware that state law requires abortion clinics to maintain complication logs identifying complications that occur from abortion procedures performed at facilities; is that right?

A. Absolutely.

Q. And Whole Woman's Health maintains those logs; is that right?

A. Yes.

Q. And the complication logs maintained by Whole Woman's Health are reflective of all of the complications that occur from abortion procedures performed at Whole Woman's Health; is that right?

A. Every complication that we're aware is indeed recorded in the complication logs.

Q. Okay. I'd like you have a look at Defendants' Exhibit 39 which is in the binder to your right.

THE COURT: Pardon me. Was that 39?

MR. STEPHENS: Yes, Your Honor. Thirty-nine.

A. I'm familiar with the documents.

Q. And these are – could you describe these documents for the Court?

A. These are internal documents from, it appears to be, all five Whole Woman's Health Clinic sites dating back to at least [28] 2012, I see here,

reflecting complications in the clinic site, things that range from re-suction or from clots or cramping or that kind of thing.

Q. So these are the complications logs that were maintained by Whole Woman's Health?

A. Internally on the clinic site, yes.

Q. And they were provided by Whole Woman's Health to your counsel in this lawsuit?

A. Yes.

Q. And were these the complication logs that were also provided to Dr. Grossman for purposes of his analysis –

A. Yes.

Q. – in this case?

Are you also aware that state law requires abortion clinics to submit abortion complications reporting forms to the Department of State Health Services for complications that occur at abortion facilities?

A. Yeah. That law went in to effect in January of 2013. I am aware of it.

Q. Right. So as of January 2013, abortion clinics in the State of Texas are required under state law to submit a separate form that would identify and describe that complication – the complication that would occur; is that correct?

A. Yes.

[29] Q. And I'd like for you to turn to the exhibit marked Defendants' 34.

A. (Complies)

Q. Could you describe the document marked as Defendants' Exhibit 34.

A. It's the Texas Department of Health abortion complication reporting form.

Q. And is this the form that you referred to that we were discussing that must be submitted to the State of Texas to identify each complication since January 2013?

A. Yes, it is.

Q. We'll have to try not to talk and speak over each other.

A. I know.

Q. I know we had a hard time at the deposition.

A. At the deposition we had a little back and forth.

Q. So just so the record is clear, the document marked as Defendants' Exhibit 34 is the abortion complications reporting form that has been required to be submitted since January of 2013?

A. Yes.

Q. What is the time frame in which that form is required to be submitted after a complication occurs?

A. As it says here, it's within 30 calendar days from the complication.

Q. And now I'd like for you to turn to Defendant's Exhibit 36 [30] in the binder. And if you could take a moment to look through each of the documents that are contained in that – in that Exhibit in Defendants' 39.

A. May I ask a question?

Q. Actually, I think I said 39. I meant Defendants' 36.

A. Thirty-six is what you want me to look through?

Q. Yes.

A. Okay. I noticed on the bottom of the form it says within 20 calendar days, but the one you gave me in the other exhibit says within 30.

Q. That's right. And that may have changed. I was going to ask you whether the time frame in your understanding had changed at some point after January of 2013.

A. From this it appears to be so.

Q. Okay. But on either form, it's either 20 days or 30 days; is that right?

A. Correct. I'm familiar.

Q. Okay. So you're familiar with these documents?

A. Yes.

Q. And could you describe these documents?

A. These are abortion complication reporting forms filled out by Whole Woman's Health facilities and sent to the State post-abortion.

Q. So these are the completed versions of the exhibit we previously looked at that's required to be submitted for the [31] State for any complication that would occur after January 2013 at a Whole Woman's Health facility; is that right?

A. Correct. The physician oversees the – the definition of a complication, and so the physician reviews that complication log that you had me look at a moment ago and then causes this form to be filled out. And so these forms are reflective -¬for example, incomplete abortion, continued pregnancy are reflecting if the patient had treatment for that complication.

Q. So the complication log is reviewed by the physician and then, based on review of the log, these forms are submitted to the State?

A. Correct.

Q. And what types of complications are required to be submitted on this form?

A. There's a list right on the form that says incomplete abortion, post-procedure infection, hemorrhage, damage to the uterus, death, or other.

Q. Are you aware of any forms that – any abortion complications reporting forms that were submitted to the State that were not contained in Exhibit 36?

A. I don't personally review every complication form that gets submitted to the State. I would assume that they're all here if they were requested by the State.

Q. And so, to your knowledge, there aren't any that are missing from Exhibit 36?

[32] A. Correct.

Q. Okay. Turning back to Exhibit 39, which is the complication log. It may be a little easier for the next series of questions if you take out the log so you can compare.

A. Uh-huh. What was the other section?

Q. I'm sorry?

A. What was the other section you want me to compare it to?

Q. D-36 and D-39. Okay. You have both of those documents?

A. I do.

Q. Okay. So referring first to the complication log, which is D-39, on the first page of that document, the second line lists a date of TOP as 7/16/13 at ASC in San Antonio. Do you see that?

A. Yes.

Q. And what does that mean?

A. What does what mean exactly?

Q. What does date of TOP mean?

A. Oh. Termination of pregnancy.

Q. So that was the date the abortion was performed?

A. Yes.

Q. And so the abortion referred to in the second line of the document marked D-39 was performed on July 16th, 2013 at the ambulatory surgical center in San Antonio owned by Whole Woman's Health; is that right?

A. Whole Woman's Surgical Center, yes.

[33] Q. That's the ASC?

A. Yes.

Q. That was – and this lists a complication that occurred as a result of that procedure; is that right?

A. I believe this complication log is from the Fort Worth clinic site, and I believe this patient was from Fort Worth, if I'm not mistaken. It's hard for me to tell because I don't see the clinic site indicated on here. But I see that HMC is Harris Medical Center, which is in Fort Worth.

And I remember this case. This patient had an abortion in San Antonio because she was over 20 weeks pregnant, and she returned to Fort Worth for her follow-up, at which time the doctor in Fort Worth decided that she needed to go for further observation to Harris County Medical Center.

Q. So the abortion was performed on July 16th, 2013 in San Antonio?

A. Correct.

Q. And then the follow-up was in Fort Worth?

A. Yes.

Q. Okay. Was this complication reported to the State of Texas?

A. I would assume so, but I don't know definitively.

Q. Is it reflected in any of the abortion complication reporting forms contained in Defendants' Exhibit 36?

MS. TOTI: Objection, Your Honor. Lack of [34] foundation.

THE COURT: Overruled.

A. I have it in front of me, yes.

Q. And which form is that?

A. Are they numbered?

Q. Well, there's a number at the bottom right corner.

A. Okay. 00005600.

Q. Okay. And that form on the first line says where and when the abortion was performed; is that right?

A. Yes.

Q. And here it says the abortion was performed at Whole Woman's Health in Fort Worth on August 5th, 2013; is that right?

A. Correct. This patient had what's called resuction procedure when she came to Fort Worth for her follow-up, so there was a second surgical procedure attempted. And the doctor in that facility chose to transfer her to Harris County Medical Center. So when she had her initial abortion procedure in San Antonio, there was no complication at that time in the San Antonio office. She was monitored, discharged completely healthy. When she came for follow-up in Fort Worth, as I read this, other issues emerged and the physician in Fort Worth chose to transfer her to Harris County Medical Center postoperatively. There was some time between the two procedures.

[35] Q. Right. So referring to the complication log again that indicates that there was an abortion performed on 7/16/13 at an ASC in San Antonio, that's not right?

A. What I see here is it says re-suction following D&E at 21 weeks. When it says the number of weeks gestation at which the abortion was performed.

Q. Right. And I'm referring back to D-39, the complication log, that indicates that a date of TOP was 7/16/2013. Is that not right?

A. That's the initial termination of pregnancy in San Antonio. But the log you're referring to is the Fort Worth log.

Q. Okay. So there was not a log for the San Antonio facility indicating that a termination of pregnancy that resulted in a complication for an abortion performed at that facility resulted in the complication; is that right?

A. What we have here is an example of some continuity of care between Whole Woman's Health facilities, and there's more than one log that I'm looking at. So what I'm seeing here is that the patient presented in Fort Worth with some issues. But in her care in San Antonio, she was discharged without complication.

Q. Okay. And on – let's refer now on D-39 to the page marked – D-39.

A. Uh-huh.

[36] Q. – which is the complication logs, to the page marked P 00005560 through 5561.

And could you describe the complications that are noted on those pages of the complication log.

A. Yes. The date range ranges from March through the end of April 2013. And I see here recorded five cases of post-mife, which is medication abortion suction procedures, for various reasons, from cramping to somebody who had what we call hyperemesis, somebody who couldn't keep any food down and needed to have a surgical procedure instead, to some bleeding issues.

Q. Okay. And I think you said it was through April of 2013 –

A. I meant through May.

Q. Through May. So there are five here?

A. Yes. So it's a three-month time period.

Q. Are these incomplete abortions? Is that how a re-suction is described?

A. I would – two caveats, I would say. One I would always defer to our medical director to define a medical complication. But common in the field would be an incomplete abortion would be when a pregnancy is continuing, ongoing, or when there's retained tissue that requires surgical or medication intervention. So there's kind of a variety listed on this log here, like the patient like I said who had trouble with nausea [37] and wasn't able to keep the mifepristone down to another patient who took the medication and never had any bleeding and came in kind of concerned that she may not have passed the pregnancy. So there's quite a range here.

Q. Okay. And these are listed as complications; is that right?

A. Correct.

Q. Now, referring back to D-36, could you identify the abortion complication reporting forms that were submitted for these procedures for those complications?

MS. TOTI: Objection, Your Honor. There is no foundation as to whether this is the complete universe of forms that was submitted by Whole Woman's Health to the Department of State Health Services.

THE COURT: Well, I don't think that has been posited by the defendants. The objection is overruled. Mr. Stephens may continue his cross-examination.

A. Let me just make sure I understand what you're asking from me. You want me to find the complication form for each of these five?

Q. Yes. If you could.

A. It's taking some time only because the log doesn't indicate which clinic.

Q. And that's actually a question I had for you. You said that these logs were reflective of all five of the Whole [38] Woman's Health clinics?

A. I'm assuming so.

Q. Okay. But you don't know if there's a log for each clinic or is there a log for each clinic?

A. Absolutely there is a log for each clinic. I'm unclear as to whether you have all five clinics here bunched together or not.

Q. Do you know if Dr. Grossman had the logs for all five clinics?

A. Absolutely he did.

Q. Okay. So I'll go back so the record is clear. My earlier question was asked, if you would please identify the forms submitted as abortion complication reporting forms submitted to the State for the complications that occurred from the abortions performed on the dates identified – 3/21/13, 3/5/13 4/19/13, 5/24/13, and 5/2/13.

A. I don't find them here.

Q. I'm sorry? I couldn't hear the answer.

A. I don't find them here.

Q. Okay. Do you know whether there has been any complication from an abortion performed at the San Antonio ASC since January 1st, 2013 – the San Antonio ASC owned by Whole Woman's Health?

A. I don't know definitively yes or no.

Q. Okay. Can you identify which of the complication logs in [39] the Exhibit 39 are from that

facility? And you could refer to them with the page number on the bottom right if you can find those.

A. I'm just going to tell you as I find them because there's a lot of years here, 2011 to present, from five sites.

Q. Okay.

A. But one page that looks like it's from San Antonio is P 00005589, P 00005597 It's going to be a little challenging to keep them separate. This one actually goes back to 2010, August of 2010, 00005605. They're all upside down now, so bear with me. 00005607. I think this is a duplicate. I've already – it's a duplicate copy of the same log. I believe 00005611 is the same exact page as 00005597 They appear to be both from San Antonio, but they're the same piece of paper.

Q. Okay. And so you – two of those that you referred to, I believe, are P 00005607 and 5597; is that right?

A. I don't recall what I told you. You're going to have to – I'm going to have to trust you to remind me.

Q. Okay. Could you have a look at P 00005607.

A. Yes. Actually, this is – yeah.

Q. So this is one of the complication logs from the San Antonio ASC; is that right?

A. Yes.

Q. Okay. The complications that are listed on this log, are those contained in any of the forms that are – that were [40] submitted to the State in D-36?

A. I don't see them here, but I'm not confident these are all the forms. I don't see them here.

Q. And, in fact, there are no abortion complication reporting forms contained in Exhibit D-36 for any abortions listed on the form as performed at the Whole Woman's Health ASC in San Antonio; is that right?

A. So surgical complication reporting in an ambulatory surgical center is a little bit different than an abortion facility. There's other regulations in place for how we have to report complications for an ASC. This would be one of the ways, because it's abortion specifically. But ASCs have sort of higher guidelines when it comes to reporting because there's an assumption you're doing multiple surgeries. So there's two different ways to report. But the pieces of paper you have – you've given me here don't indicate anything from San Antonio.

Q. Okay. Thank you. Okay. You can set these exhibits to the side.

A. Can I leave it sort of messy?

Q. Sure. All right. Of course, as I tell you to set it to the side, I do have one other question about the complication logs.

A. Okay.

Q. Could you identify the complication logs that were submitted for the Whole Woman's Health facility in McAllen in [41] D-39? I realize they're not labeled by facility. That's why I'm having to ask you to identify them.

A. Some of these are blank. I don't – I can't definitively say that any of these are from McAllen. There's a few pages that say no complications in this time period that could be from McAllen. But I don't – I can't tell.

Q. And do you know whether McAllen maintained a complication log?

A. Absolutely. Yes.

Q. They did?

A. Uh-huh.

Q. Are complication logs required to be completed within a certain time period of the date of the abortion?

A. It is our practice to complete them as soon as possible from the medical chart as directed by the physician. And they are reviewed by every surveyor annually when the surveyor comes through for the annual inspection of the facility.

Q. And why is it part of the practice of Whole Woman's Health to complete the logs as soon as possible after the procedure?

A. Because it's part of a rigorous quality assurance program.

Q. I'd like for you to turn to the page 5668, which is one of the complications logs.

A. Yes.

Q. And do you see at the bottom of that form where the form itself says that it was updated March 2013 AF?

[42] A. Uh-huh. I do.

Q. Is that right?

A. Yes.

Q. And I believe you explained those notations at the bottom of certain Whole Women's Health documents at your deposition as being the date in which a form was created or modified.

A. Correct.

Q. Is that right?

A. Correct.

Q. And "AF," is that Andrea Ferrigno?

A. Andrea Ferrigno. Uh-huh.

Q. And what is her role at Whole Woman's Health?

A. She's the corporate vice president.

Q. Okay. This form was created or updated in March 2013?

A. It was updated by her. It was created by me.

Q. Okay. And the complication that is handwritten on this form, the date of the abortion was January 5th, 2012; is that right?

A. Correct.

Q. So that could not have been entered on this form until after March 2013; is that right?

A. It appears so.

Q. So that was entered at least a year after the abortion was performed?

A. It appears so by this form.

[43] Q. And if you turn that page over to 5567, the abortion performed on that page was September 20th, 2012; is that right?

A. Correct.

Q. And that form was printed in, well, at the earliest, March 2013; is that right?

A. Correct.

Q. You mentioned annual inspections that occur of abortion facilities in the State of Texas. Could you describe the nature of those types of inspections?

A. It's a surprise visit that's conducted annually for every single facility by a surveyor from the health

department. The surveyor usually spends a day or two, sometimes three, in the facility and has a survey tool produced by the health department that they follow. They do things ranging from observing a procedure, observing patient care, to auditing charts to reviewing medical logs and protocols, physician personnel files, staff personnel files, et cetera.

Q. Okay. And are you familiar with a form that is called a Statement of Deficiencies and Plan of Correction?

A. Yes, I am.

Q. Okay. And could you describe that form?

A. So the common course of an inspection would be that the surveyor comes in, does a walk-through. Usually we have an exit conference where we sit down with the surveyor and he or she goes over her findings of the visit. Sometimes those [44] visits result in deficiencies.

In the normal course of interaction with the health department, the health department will send you a list of any deficiencies they found. They're usually not a surprise because they've talked to us about them face to face at the exit conference. They send us a list of deficiencies, we write a plan of correction, that plan of correction is approved by the health department. It's sort of a conversation back and forth, and then we go about completing that plan of correction.

Q. Okay. So the state – and so the statement of deficiencies and plan of correction is a document that is created by the Texas Department of State Health Services; is that right?

A. The statement of deficiencies is created by the health department. The plan of correction is created by Whole Woman's Health. We send it back to them within the required time frame, and then it becomes a document that has both sides reflected on it.

Q. Okay. I see. Could you look to Defendants' Exhibit 27?

A. Yes.

Q. And this is an example of a statement of deficiencies and plan of correction that you referred to?

A. What you have here are two different results of an annual survey at Whole Woman's Health in McAllen. The first is from 2012, and the second is from 2013. The first would be a [45] complete reflection because it includes our Whole Woman's Health plan of correction. The second document you sent only includes the health department deficiencies and doesn't include our plan of correction.

Q. Is there a plan of correction for the 2013 inspection?

A. Absolutely. It's due to the health department within 10 days of receipt.

Q. Okay. But, to your knowledge, this is a document that reflects at least as – as shown in the deficiency side of the document, the observations that were made by the Department of State Health Services at that annual inspection; is that right?

A. I wouldn't call this a complete document because it doesn't reflect the plan of correction that was accepted by the health department.

Q. Right. It doesn't reflect the subsequent plan of correction provided by Whole Woman's Health?

A. Correct.

Q. On page – these don't have numbers on the right side, so I'm just going to have to ask you to flip to the page. It's the fifth page of the document.

A. There's two documents here. Of 2013 or 2012?

Q. It's the fifth page of the exhibit.

A. Okay. They're double-sided. You're throwing me off. This one?

Q. Do you see the one that says 3 of 5 on the bottom right [46] corner?

A. Yes.

Q. And then it's – it has A 118, 139.8 A, quality assurance. We're on the same page?

A. Yes, we are.

Q. Could you describe the quality assurance program that existed at – the Whole Woman's Health McAllen clinic at the time of this survey?

A. Yes. The quality assurance program at Whole Woman's Health McAllen is the same program we have at all of our facilities. There is sort of a quality assurance working tool where we have a comprehensive scan of all the practices in the office, where the physician, a nurse, and two other staff members meet quarterly to review the practice of the clinic, everything from personnel files to evaluating, you know, independent contracts to looking through the physical plant, equipment. We look over the medical complication logs that are sometimes trending and analysis of – if there was any – ever any patient complaint, that would be addressed at that point. We review patient satisfaction surveys to make sure that the practice is up to our standards. That kind of thing.

Q. Okay. And do you see on this document where the findings indicate, quote, interviewed facility administrator. And at the time of the survey, the clinic administrator was unable to locate any quality assurance documents for the previous year?

[47] A. Yes. I do see that. And that's one of the reasons I would argue this document is incomplete, because those documents were produced within the 10 days required by the health department during this inspection period.

Q. You provided a plan of correction to address that?

A. I provided the quality assurance program documents, not the plan of correction. I did both.

Q. So it's your position that at the time of the inspection, those documents were available. They just weren't provided to the inspector?

A. Exactly.

Q. And the facility administrator at the time of the inspection didn't have those documents; is that right?

A. The facility administrator didn't understand the question from the surveyor, and part of the plan of correction was disciplinary action and reeducation of that administrator.

Q. And who was that administrator?

A. Christina Banda. She's a nurse.

Q. Turning to—turning to the next page which is marked 405, the document notes that this requirement is not met as evidenced by review of facility personnel files and interviewed facility administrator and found that annual evaluations on personnel had

not been conducted at all facility—on all facility personnel. Administrator agreed that all annual evaluations had not been completed, to include [48] her annual evaluation. Do you see that?

A. I do see that.

Q. And do you agree with that?

A. I agree that that's the finding. I also know that we took care of that in the plan of correction as well.

Q. Okay. So it was—at the time of the annual inspection, it had not—that requirement of—with DSHS's personnel policies had not been complied with?

A. At the time of the inspection, the administrator was overdue for her performance evaluation.

Q. The next line identifies that two out of seven staff members had expired CPR certifications; is that correct?

A. That's what the health department says. Prior to the health department inspection, we had just done a recertification and we were awaiting—it was a few days before, actually, and we were awaiting the—like, kind of the master list from the agency that came and re-certified the staff for CPR. And we were able to produce that for the health department to prove that all the people had actually been re-certified within the time frame.

Oftentimes the health department asks for documents that you need to produce, and you have 14 days during that inspection time to produce them. So that was produced during that time frame.

Q. So the plan of correction addressed that after the fact?

[49] A. Actually, it was addressed—the people were certified in CPR prior to the inspection date. We weren't able to prove it with a piece of paper from the vendor we used until, you know, a day or two after the inspector had left the premises.

THE COURT: At this time we'll take our morning recess, and we'll be in recess for 15 minutes.

(Recess)

(Open Court)

THE COURT: Mr. Stephens, you may continue your cross-examination.

MR. STEPHENS: Your Honor, I would like to offer what's marked as Defendants' Exhibit 27 into evidence.

MS. TOTI: Your Honor, as to the pages that don't include the plan—

THE COURT: I can't hear you. You're going to have to either come to the podium or talk right into the microphone.

MS. TOTI: As to the pages that don't include the plans of corrections, we would object on hearsay grounds.

THE COURT: I'll overrule the objection and admit the exhibit. The witness has, I think, clearly identified it and has familiarity with it. And so the objection is overruled. Defendants' Exhibit Number 27 is admitted.

MS. TOTI: Your Honor, may I request that they be admitted not for the truth of the matter alleged in them, but simply that these were the forms created by the department?

[50] THE COURT: No. I'm not going to limit the exhibit. The exhibit has been thoroughly explained by the witness, and the Court understands it. So I'm admitting it. It speaks for itself.

Q. (BY MR. STEPHENS) Ms. Hagstrom-Miller, you testified in your direct testimony that, after October 31st, 2013, the McAllen Whole Woman's Health clinic was opened for approximately four months; is that right?

A. Correct. We were no longer providing abortion services, but we were open.

Q. Right. And I believe that you testified that during that four-month period, the McAllen Clinic continued to provide non-abortion services such as pregnancy testing, ultrasound, and contraceptive counseling; is that right?

A. Correct.

Q. And during that time, that four-month time period, certain women came to the McAllen clinic seeking abortion services; is that right?

A. Yes.

Q. And those women who came to the McAllen clinic during the four-month time period seeking abortion services were referred to San Antonio; is that right?

A. The women we serve in McAllen come from a range of different backgrounds. Some women were referred to San Antonio if they had a car, if they were able to travel. A significant [51] percent of patients we serve in the McAllen area are in this country legally but on a restricted visa that doesn't allow them to travel north of Falfurrias, and so those women we weren't able to refer anywhere. But some of the women who were able to travel, we were able to help try to travel north. But it was pretty small percent of people that were able to make the trip.

Q. Right. And each of those women who requested help to get to San Antonio I think, as you said, was provided funding by a fund that Whole Woman's Health had organized; is that right?

A. We organized a fund to assist women who were able to make the travel north. We offered them either a bus ticket or a gas card. But to date the—we've only been able to support eight or nine women

for a total of about $700. So it was a very insignificant percent of women who were able to travel north.

Q. I believe at your deposition in this case, you testified that every woman who asked for financial assistance for the bus ticket to get to San Antonio was provided that funding; is that right?

A. We offered it to everybody who asked for it.

Q. And you didn't refer any of the patients—or any of the women who came to the clinic in that four-month period to Corpus Christi, right?

A. No.

Q. They were all referred to San Antonio?

[52] A. Well, some wanted to go to Corpus Christi if they had family there or if it was—you know, if they were familiar with the area. A lot of times folks in the Rio Grande Valley are a little bit nervous about going to a city—a big city. For some people in the Valley, San Antonio is kind of in the valley and Corpus feels really different unless they're from the Brownsville/Harlingen area.

Q. Right. I understand. So Corpus, even though it's closer, you didn't necessarily refer any of the women to Corpus unless they specifically wanted to go to Corpus; is that right?

A. Correct.

Q. And why didn't you refer any of the women to Corpus despite Corpus being a closer driving distance than San Antonio?

A. Because I don't think proximity is the most accurate measure of quality of care. I think that the care that they were able to get in our San Antonio office was superior.

Q. Okay. So it could potentially be more difficult for the women to get to San Antonio than to Corpus, but it was a decision based on the quality of care; is that right?

A. If it was easier for her to get to Corpus, we would in no way prevent her from doing that.

Q. But you never referred a single woman to the Corpus clinic unless she specifically said she wanted to go to Corpus?

A. That's not what I testified. I said, if a patient wanted [53] to go to Corpus, we helped her go there.

Q. Okay. You helped her go there. But you didn't recommend she go there?

A. I would not—I'm not exactly sure what you're getting at with your question. Could you rephrase it, please?

Q. My question is: Unless a woman specifically requested assistance to go to Corpus, Whole Woman's Health did not refer any patients to the Corpus clinic operated by Dr. Aquino?

A. If a woman came in and said, Where can I get an abortion? and we said we can no longer provide them here, and she said, Where could I go? we would tell her about all the options in the State, including Corpus.

Q. Okay. Could you turn to the document that's marked as D-15, which is Defendants' Exhibit 15. Are you familiar with this document?

A. Yes.

Q. And could you describe the document marked as D-15?

A. It's an E-mail exchange between myself and Erik Eckholm.

Q. The document I have as D-15 is between you and Kathleen Osborne. Maybe I have the wrong document?

A. Maybe I'm looking at the wrong one. That one's here, too.

Q. Okay. And is it marked as D-15?

A. Yes. On the top right it is.

Q. Okay. And I'd like to look at the E-mail at the bottom of the first page and that continues onto the second page. Do you [54] see that?

A. Yes.

Q. And that's an E-mail from Kathleen Osborne to you; is that right?

A. Correct.

Q. And then you responded to that E-mail, and your response is in all caps; is that right?

A. Yes.

Q. Could you read the—beginning at bottom of the first page of this E-mail the question posed by Ms. Osborne in the E-mail?

A. Does it start with the word "working"?

Q. Yes.

A. "Working ahead for tomorrow. Just wanted to double-check one thing right now. There's still a clinic offering terminations in Corpus Christi, I believe. When we talked, we discussed that the next option is San Antonio. What about Corpus?"

Q. Okay. And then did you respond to that question?

A. I did.

Q. Okay. And what was your response?

A. "Yes. He is open. I am not a big fan of his clinic. Not a woman's center or compassionate facility, but he does empty uteruses safely and legally. He will only be open until September, as he doesn't have an ASC. But, yes, he is there, [55] but we don't refer to him."

Q. Okay. And "him," that's—is that referring to Dr. Eduardo Aquino?

A. Yes.

Q. And do you know whether Dr. Aquino plans to open an ASC in San Antonio with Dr. Braid?

A. I don't know.

Q. Okay. If you obtain financing, will you open an ASC in Fort Worth?

A. I have tried to obtain financing for an ASC in Fort Worth, and to date I've been rejected by over 15 banks.

Q. If you obtained financing, will you open an ASC in Fort Worth?

A. At this point I will not.

Q. You will not?

A. No.

MR. STEPHENS: No further questions, Your Honor.

THE COURT: Redirect, Ms. Toti?

MS. TOTI: Yes, Your Honor.

[REDIRECT EXAMINATION]

[BY MS. TOTI:]

Q. Hello again.

A. Hi.

Q. So Mr. Stephens asked you a number of questions about the complications logs maintained by Whole Woman's Health. Do you [56] recall that?

A. Yes, I do.

Q. Can you tell me about the process for maintaining these logs at Whole Woman's Health?

A. So each clinic has its own log stored at the clinic, and complications are entered into that log as directed by the physician or sometimes that result from postoperative conversations with our nurse who is on call.

Q. And are the logs maintained at a central location, or are that he maintained at each facility?

A. They're not centralized. There's one log for each clinic site kept on site at the facility.

Q. Now, Mr. Stephens asked you about a page in Exhibit D-39. I'm going to ask you to try to find it again. Turn to D-39.

A. Yes.

Q. He asked you some questions about the page with the Bates Number P 00005568.

A. Yes.

Q. And this—these questions concerned the fact that this form had been updated in March 2013; is that correct?

A. Correct.

Q. Do you recall why the forms were updated at that time?

A. We update our forms oftentimes as a result of health department regulation changes that result from quality assurance program reviews. So sometimes we will do an update [57] for those reasons. We also have an annual review of all of our protocols and paperwork at Whole Woman's Health that will trigger an update if a form needs to be changed or revised.

Q. And when forms like this that cover a long period of time are updated, do you ever transfer the information from prior forms to new forms?

A. Yes, we do.

Q. And is that what happened in this instance?

A. It's quite possible, yes.

Q. I'd like to ask you to take another look at Defendants' Exhibit 36.

A. Are those the complication forms?

Q. Yes.

A. Sorry. My book is a mess.

Q. Are these the complication reporting forms that Mr. Stephens asked you some questions about?

A. Yes.

Q. As you sit here today, do you have any way to know whether this is the complete universe of

forms that's been submitted to the health department by Whole Woman's Health?

A. Absolutely not.

Q. So there may be additional forms that aren't provided here?

A. Correct.

Q. So there's no way as you sit here today to reconcile these [58] forms with the entries on your complication logs; is that correct?

A. Correct.

Q. And there's no way for anyone to draw the conclusion that certain forms—well, strike that.

I believe you testified that your complication logs were shared with Dr. Daniel Grossman so that he can perform an analysis as part of his role as an expert witness in this case; is that correct?

A. Correct.

Q. And do you have an understanding of the analysis that Dr. Grossman performed?

A. I do.

Q. Do you know which of the Whole Woman's Health facilities he looked at?

A. San Antonio, both the ASC and the clinic facility there, Austin, and Fort Worth.

Q. Did Dr. Grossman review complication logs from the McAllen clinic?

A. No.

Q. Why not?

A. Because it was closed.

Q. Did he review complication logs from the Beaumont clinic?

A. No.

Q. Why not?

[59] A. It was also closed.

Q. So those logs were not provided to him, correct?

A. Correct.

Q. And those logs were not provided to your counsel to transmit to the State as part of their request for the logs reviewed by Dr. Grossman; is that correct?

A. Correct.

Q. Now, I believe you answered some questions about the process for receiving deficiencies and submitting plans of correction; is that correct?

A. Correct.

Q. Can you just go through that—that process for us so we have a complete understanding?

A. Yes. So every year the State Department of State Health Services has a surprise visit to our facilities and through the course of that visit they review a number of things, from quality assurance programs to personnel files, doctor files, they observe—some of the surveyors observe direct patient care, some do not. They do a chart audit, random chart audit, they do a walk-through of the facility, monitoring of the physical plant and the equipment, that kind of thing.

Q. And—and can you tell us a bit about the statements of—of deficiency. How does that process work?

A. Yes. So we've been through—we've had a lot of inspections at Whole Woman's Health. With five facilities over [60] the last 11 years, I think we've probably had 60 or 70 abortion facility licensing inspections. As part of the process they always do an exit conference. They sit down with us and kind of talk over what they found. Sometimes that is an opportunity for some clarification. The vast majority of the time there aren't any deficiencies, and we move forward from there.

Every once in a while there is a deficiency or a couple of deficiencies that we will need to discuss with the health department. They send us a report of deficiencies. As I said, we would write a plan of correction to address those deficiencies. That plan of correction is reviewed and accepted by the health

department, and it's monitored by them from there forward.

Q. Do you sometimes contest deficiencies that are stated in the notice from the health department?

A. Oftentimes at that exit conference there's some clarification that happens where an assumption is made and we make some clarifications. We have never been in a position to challenge a deficiency until this year, where we have challenged more than one deficiency in recent inspections.

Q. So if you're looking simply at a statement of deficiency without knowing what Whole Woman's response to that statement of deficiency is, would you have complete information about the situation that transpired at the clinic?

A. Absolutely not.

[61] Q. Would it be fair to say you just have one side of the story?

A. Correct. And it would be very much out of context. The plan of correction, as I said, is approved by the health department. And so that—that sort of inspection process isn't really complete until the deficiencies, the plan of correction, and the approval has happened.

Q. So transmission of a statement of deficiencies is simply one step in a lengthy process. Is that your testimony?

A. Correct. Yes.

Q. Are you aware that, prior to this lawsuit, there was a previous lawsuit that contested the admitting privileges requirement that's also at issue here?

A. Yes.

Q. Was Whole Woman's Health a plaintiff in that lawsuit?

A. Yes, we were.

Q. Did you—did you testify in court during those proceedings?

A. Yes, I did.

Q. Approximately when was that?

A. You know, this year has been a little bit of a blur, but it was in 2013 at the end of the year.

Q. Okay. And is it your understanding that the lawsuit was filed, you know, a little bit earlier than that?

A. Absolutely. Before, yes. Absolutely.

[62] Q. Prior to Whole Woman's Health serving as a plaintiff in that lawsuit—and I'm going to refer to it as *Abbott*.

A. Okay.

Q. Prior to Whole Woman's Health serving as a plaintiff in the *Abbott* case, what was the frequency

with which you received deficiency notices from the department?

A. It was an exception. It was pretty uncommon. We would get deficiencies every once in a while, but it was very uncommon.

Q. And has that changed since the time that Whole Woman's Health served as a plaintiff in the *Abbott* case?

A. Absolutely.

Q. How has it changed?

A. We have had numerous inspection reports. We have had multiple complaint visits with the health department showing up in one office as many as three. We have had deficiencies escalate, and we've had to appeal more than one deficiency at more than one clinic site.

Q. Has there been any change in the tone of the interactions between Whole Woman's Health and the Department of State Health Services?

A. Yes.

Q. And can you describe that for me?

A. A very significant change, almost to the point of having it feel adversarial—the health department inspector refusing [63] to leave the premises without us copying 50 medical charts while we're in the middle of seeing patients. Actually went so far as to say, unless it was a patient emergency, we should stop

taking care of patients and copy the charts for her. Very adversarial, uncomfortable, disruptive.

Q. Okay. So I want to direct your attention back to Exhibit D-27, which is the collection of statements of deficiency, most of which do not have plans of correction attached to them. Do you recall answering some questions about this exhibit?

A. Yes, I do.

Q. Would it be fair to say that many of the deficiencies cited have to do with failure to provide records at the time of the inspection?

A. Yes. Many of these deficiencies are related to administrative matters.

Q. Do you have an—I thought I heard you testify in response to Mr. Stephens' questions that you have a certain period of time after an inspection to submit records. Can you say a little more about that?

A. Yes. It's my understanding that there's—like I said, there's some back and forth in the reporting and the inspection process, where the surveyor will ask for materials and then we give them to him or her and then, you know, she may ask for more and there is some back and forth.

[64] I've experienced two survey—annual survey inspections that have actually lasted over three months, where there's a back and forth of requesting materials. When the surveyor is on site and requests

materials that we are unable to either locate or produce that day—say, for example, patient charts that might be stored off site—there's a time period in which the DSHS regulations allows us to produce those materials and it's not considered a deficiency unless we're unable to produce them. And I believe that time period—it's in the regulations. I believe it's 14 days.

Q. And it was your testimony that, for the deficiencies that Mr. Stephens pointed out to you, you, in fact, submitted the required documentation within the—the permitted time period?

A. Absolutely. I've been thinking about the McAllen inspection specifically since he asked me about it, and we produced the QA materials very quickly. I know we produced the CPR roster—I couldn't figure out—I couldn't remember that word a minute ago—the CPR roster actually the same day that the surveyor was there.

Q. And all of the—the deficiency notices contained within Exhibit—Defendants' Exhibit 27 are dated 2012 or 2013; is that correct?

A. Yes.

Q. And, in fact, the vast majority are dated September 2013; is that correct?

[65] A. Correct.

Q. Okay. Mr. Stephens had asked you some—some questions about providing assistance to patients

who presented for abortion services in McAllen after that clinic had ceased providing abortion services. Do you recall those questions?

A. Yes, I do.

Q. Can you describe in a little more detail what that program consisted of?

A. We had some money from an abortion fund to offer women assistance for traveling if they needed it. So we would—if a woman, you know, wanted to have the abortion, we were no longer able to provide it at Whole Woman's Health of McAllen. And so sometimes she would express difficulty in being able to travel north. So if she had a car and was able to take time off work and get her child care covered, we would offer her a gas card. And if she didn't have a car, we would offer her a bus ticket. It was our hope that we could assist women, but we were actually not able to assist that many.

Q. And why is that?

A. Because the majority of women found it too much of a burden to get time off work, get child care, travel north for a couple of days. Irrespective of the gas card or bus ticket, it wasn't enough help.

Q. And how do you know that?

A. Because they told us that.

[66] Q. And so what—I think you just mentioned a couple of things, but what is your understanding of what was preventing these women from

accepting the gas cards or bus tickets and actually making the trip?

A. The majority of time they couldn't make the commitment to be away from their family or away from their job for more than a couple of days. The round trip from McAllen north is a significant amount of time and, you know, there is usually a hotel stay involved as well as the patient has to come in, you know, for—depending on her gestation and depending how far from the clinic she lives, sometimes it requires more than one visit.

So the vast majority of women we serve are mothers already. And so getting time off work and getting child care and also paying for the abortion and also traveling, it's just too many barriers for that woman to overcome.

MR. STEPHENS: Your Honor, we're going to object to this testimony as hearsay to the extent that it purports to describe what women in the Rio Grande Valley told Ms. Hagstrom-Miller about the reason for going to a clinic or not going to a clinic.

THE COURT: You need to stand up when you address the Court.

MR. STEPHENS: I'm sorry, Your Honor. The State would object to this testimony to the extent—as hearsay to [67] the extent that it is offering testimony provided to this witness by women in the Rio Grande Valley who are not in court to testify.

THE COURT: Ms. Toti?

MS. TOTI: Your Honor, Mr. Stephens asked Ms. Hagstrom-Miller about this program and why it was limited in scope, and she's testifying about the basis for her understanding about why more women weren't able to utilize it.

THE COURT: Well, she can testify as to her understanding, but the objection is sustained as to the truth of the matter because the persons who made statements to her are not present in court and subject to cross-examination.

Q. (BY MS. TOTI) So how many women during this time period presented at the McAllen clinic?

A. Initially, almost the same amount of women when we were able to provide abortion services. So we may have seen 50 to 60 women a week. Initially a lot of the women—and, actually, still to date some people are really confused about whether abortion is legal or whether it's not, whether we can offer it or not. And so our phone was still ringing and patients were walking in the front door. And so, you know, we would have 40 to 50, sometimes 60 women, either calling, walking in, or seeking help during that time period per week.

Q. And you were prepared to provide gas cards and bus tickets to all women presenting for abortions at the clinic, correct?

[68] A. Correct.

Q. How many women actually accepted that offer?

A. During the time frame we're talking about—I mean, the total amount we had funded I believe was in the ballpark of $1,500 to date. And during that time frame I believe it was 7-or 8-hundred dollars at that time, which represents about eight or nine women total.

Q. So 50 or 60 women per week over a four-month period, but only—I'm sorry. What was number that you just said about the acceptance?

A. Eight.

Q. Only about eight women accepted—

A. Right.

Q. —the offer of cash assistance?

A. Right.

Q. Do you—I believe in your direct testimony you made reference to an immigration checkpoint in the Rio Grande Valley?

A. Correct.

Q. Do you have any understanding of how that immigration checkpoint may present an obstacle to some of the patients that visit your McAllen clinic?

A. Yes, I do. The—there's many women in the Rio Grande Valley area who have a specific visa that allows them to be in the Rio Grande Valley. People come back and forth for [69] shopping, for medical

care. I forget the name of the visa, but there's a visa that allows you to be in the Rio Grande Valley.

It forbids you from traveling north as—even to Corpus Christi and to San Antonio. So that border checkpoint at Falfurrias is where—is the farthest north point, which is about 45 minutes north of McAllen.

Q. And just to try to clarify something that I think wasn't totally clear based on your cross-examination, if a patient during this time period, when the McAllen clinic was open but not providing abortion services, indicated a preference to go to Corpus Christi to receive abortion services, what response would she get from the McAllen clinic?

A. If she wanted to go to Corpus because she—you know, it was closer, it was easier for her to get to, she had family, we would offer her assistance to go there as well.

Q. But you don't generally refer patients there?

A. No.

Q. Is there a difference in the scope of services that are provided at the Corpus Christi clinic and your Whole Woman's Health ASC in San Antonio?

A. Yes. Both in medical care and what I would call, sort of, you know, the comprehensive care model. Both. So in San Antonio we have an ambulatory surgical center. Prior to HB 2, we offered care through the 24th week of pregnancy. Now we offer

care to the 20th week of pregnancy. We're also able [70] to offer more robust pain management options in the ambulatory surgical center setting.

Whole Woman's Health also has a holistic approach to abortion care that involves counseling services and some emotional kind of support services that aren't necessarily available at all facilities in the State.

Q. If a woman was going to be delayed beyond 16 weeks of pregnancy in obtaining an abortion, would she be able to obtain that abortion at the Corpus Christi facility?

A. No.

Q. Would she be able to obtain it at your San Antonio ASC?

A. Yes.

Q. I believe Mr. Stephens asked you a couple of questions about your efforts or plans to establish additional ASCs in Texas. Do you recall that?

A. I do.

Q. Can you tell us a bit—well, let me ask this: Subsequent to the enactment of the ASC requirement that's at issue in this case, did Whole Woman's Health make any efforts to explore the possibility of compliance with that requirement at its non-ASC facilities?

A. Yes. We looked into what it would cost us to retrofit a facility or to do construction to meet the standards. I have been looking at those regulations as far back as 2006, because those regulations—HB 15 passed in 2006 requiring all [71] abortions over 16 weeks to be done at an ambulatory surgical center. So I've been familiar with those regulations since that time and had been searching from 2006 all the way to 2010 for a facility in the State that we might be able to lease or purchase so that we could resume care of women beyond 16 weeks. And that's when we were able to find the facility in San Antonio in 2010. But that took us a long time to find one that we could afford. So I was very familiar with the ambulatory surgical center regulations as well as kind of the marketplace in the State.

Q. Subsequent to the enactment of the ASC requirement that's at issue in this case, did you make any efforts or do any research about the possibility of leasing an existing ASC or space in an existing ASC?

A. Yes. I directed my staff at Whole Woman's Health, and we contacted every single ambulatory surgical center that's currently licensed in the State within 30 miles of any hospital where our physicians had privileges. So we did a very comprehensive scan, and actually cold called all the ambulatory surgical centers find out if any of them were for sale or for lease throughout the State.

Q. And did those efforts prove fruitful?

A. Not really, no. Those efforts—we did find, of all the ambulatory surgical centers within 30 miles of St. David's here in Austin, we found one that we pursued and we had a lot of [72] progress with. It was on near Seton here on 38th and Lamar. And we were in negotiations with the physician about either selling or leasing. He was very supportive and proactive.

And we got all the way to the point of taking a look at a lease and found out that there was a covenant on the building that basically restricted—I don't know if I'm using the right language—but a restricted deed on the building—property and premises that restricted the provision of tubal sterilization, vasectomy, and abortion at that address.

Q. And how did you find out about this covenant?

A. From the property manager who gave me the lease to look at as we were in negotiations.

Q. Okay. I'm going to show you Plaintiffs' Exhibit 66.

A. Okay.

Q. Are you familiar with that document?

A. Yes, I am.

Q. Is that the document that you just referred to?

A. Yes, it is.

Q. So that was provided to you by the property management company?

A. Right. On behalf of Dr. Moscoe.

Q. Can you take a look at the second page of that document, the second page Bates Stamped P 00001417

A. Yes.

Q. And can you take a look at the paragraph labeled P.03, [73] Prohibited Activities.

A. Yes.

Q. Can you please read that?

A. It says, "Prohibited activities. Lessee shall not perform or permit the use of the leased premises for sterilization procedures, abortions, or the promotion of such activities, collectively, the prohibited activities."

Q. Did you take any steps as a result of the information provided in this document?

A. Yes. I had numerous attorneys review it and try to figure out if there was a way around it.

Q. And did—did this document have an impact on the transaction that you were trying to enter into, vis-a-vis, this ASC in Austin?

A. Yes. It promptly ended the transaction.

MS. TOTI: Thank you. Your Honor, Plaintiffs' would like to move Exhibit 66 into evidence.

THE COURT: Any objection?

MR. STEPHENS: Possibly, Your Honor. We have to find it in the stack of documents that Plaintiffs provided.

No objection, Your Honor.

THE COURT: Plaintiffs' Exhibit 66 is admitted.

MS. TOTI: Thank you, Your Honor.

Q. (BY MS. TOTI) Have you made any efforts to purchase an ASC in Texas since the enactment of the ASC requirement at issue in [74] this case?

A. Yes. Like I said, we made phone calls to find out if any existing facilities were for sale or for lease. In addition to that one lead we were able to get in Austin, we had a few opportunities come up for us in Fort Worth—three to be exact. We visited all three of them and had conversations with the owners. We've ruled out one immediately because it was substandard. We ruled out another one because it was far too big. It was a 20-bed and PACU that's insider lingo, but it was a huge facility—four O.R.s, 20 beds—beyond our scope of service and beyond our budget.

We focused on one facility in Fort Worth. Really up until last week I focused very strongly on one facility in Fort Worth that perfectly met our needs that is two O.R.s, four beds, and PACU and was

appraised at 2.4 million. And I proceeded to try to get financing for that facility.

Q. So you—you said that the facility is valued at—I'm sorry. The facility was appraised at $2.3 million?

A. Yes. Sorry, yes.

Q. And that would be the value of the purchase?

A. Yes.

Q. And you made some efforts to obtain financing to—to purchase this facility for $2.3 million?

A. I did.

Q. Can you describe those efforts?

[75] A. Unfortunately during this time period, and really as a direct result of HB 2, even some of the people that I had gotten financing from before became much more wary of further investment in our facilities, both the business operations and the physical plant.

So during this time frame—actually, in May of 2014, my business partner of 10 years proceeded to convert his shares in the company to debt so that he could no longer be a partner at Whole Woman's Health specifically as a result of being worried about his assets. I also—so he was no longer an option for me to look to for funding.

I also reached out to other people in the industry and in the field nationally who sometimes have expressed interest in—in working with Whole Woman's Health and growing with us. And here again people felt like an investment in Texas was very risky.

MR. STEPHENS: Object to the hearsay, Your Honor, to the extent she's offering testimony about what the people she reached out told her about an investment in Texas.

MS. TOTI: Your Honor, she's testifying as to her understanding of why she wasn't able to recruit any capital investors to her business.

THE COURT: I will allow the testimony only as it shows what her ability was to act. So the objection is overruled.

[76] Q. (BY MS. TOTI) You can proceed, Ms. Miller.

A. In addition to sort of those private options, I met—I found out about a group—a financial group that does brokering on behalf of physicians who want to build ambulatory surgical centers all across the country. I found—their acronym is CMAC. I found them through, actually, the administrator of the facility we were looking at in Fort Worth.

And they met with us and, you know, and we gave them all of our financial information. And they assisted in brokering on our behalf to try to get us a loan from banks. And through them is where we've—I just found out at the end of last week that we've been

rejected by more than 15 banks. Some banks rejected us right up front specifically because of the nature of the services we provide. According to the banks, they felt like it wasn't something they wanted to invest in. And then a few banks went quite a bit further than that and rejected us basically on the basis of our financial picture, saying that there's no way we could sustain the ability to pay a loan of that size.

Q. So I'm going to ask you to take a look at what's marked as Defendants' Exhibit 13. It's in the black binder you have in front of you. Are you familiar with this document?

A. Yes, I am.

Q. What is this document?

A. It's—it's an E-mail that I sent to Dr. Alan Ettinger, [77] who is the primary owner of the facility in Fort Worth. I was attempting to make as many work-arounds as I could. He'd expressed pretty clearly that he wanted to sell the facility and wasn't interested in leasing in the few times that I've gone up to talk with him and his partners. And as I was being rejected by a couple of different banks along the way, I tried another approach with him and appealed to him to do a year-long lease and kind of a lease-to-own arrangement so that we could take a look at the 2015 legislative session, because many people were saying to me it's too risky in Texas. How do you know another law won't pass that will make you not even able to provide abortions at ASCs? So I approached

him and said, How about if I lease it from you for a year, and then we can talk about ownership in 2015?

Q. And was he willing to enter into a lease-to-own agreement with you?

A. No, he was not.

Q. What is the date on this E-mail that's marked as Defendants' Exhibit 13?

A. April 3rd, 2014.

Q. In the E-mail would it be fair to say that you expressed some confidence in your ability to obtain financing to purchase an ASC?

A. Yes. Confidence is important in negotiation.

Q. As you—as you sit here today in August of 2014, do you [78] remain confident in your ability to obtain financing to purchase an ASC in Texas?

A. No, I do not. At this time CMAC was still advocating on our behalf and was more optimistic. Like I said, this last week they basically told us, There's nothing we can do for you.

Q. So it's your—it's your understanding, based on your interactions with lenders and with CMAC, that Whole Woman's Health will be unable to obtain financing to purchase an ASC facility in Fort Worth or elsewhere in the State?

A. Correct.

Q. Can I also ask you to take a look at what's marked as Defendants' Exhibit 12, also in the black binder.

A. Yes.

Q. Are you familiar with this document?

A. Yes.

Q. What is this?

A. This is an E-mail I sent to my CFO at the time, last June before HB 2 was even passed, as I was starting to take a look at preparing for the worst. The subject line is "preparing for the worst." So I asked him to remind me of what our debt ratio was, you know, what buildings—how much we had in our mortgages, how many business payments we still had, and sort of give me—give me a picture of where we were at.

Q. Okay. And the last paragraph in this E-mail says, "The more I think on it for Austin, even if this ASC bill does not [79] pass this time, we should pursue an ASC if and when we move. Have we asked the realtor to look into that?"

Did I read that correctly?

A. Yes.

Q. What did you mean by that when you wrote it?

A. Here again, this is before that bill passed. And I have noticed a national trend of regulations such as HB 2 passing and requiring abortion facilities to potentially meet ASC standards. And so we've been at the same location, Whole Woman's Health of Austin. We had two subsequent five-year leases, and the lease was up for renewal last July.

And so I was looking for other properties before I renewed the lease just in a sort of, you know, scan of the city to try to figure out, were we in the best location and was this the best property for us? So I encouraged him to add ambulatory surgical centers to that scan of places we may relocate to as we renewed the lease.

What we decided to do was just renew the lease at the current location we were in for a year to buy us some time, because it remained unclear as to whether the ASC requirement would come through.

Q. Okay. I'm going to show you two more documents.

A. Okay.

Q. Three are marked as Plaintiffs' Exhibit 19 and Plaintiffs' Exhibit 67 With respect to Plaintiffs' Exhibit 19, are you [80] familiar with that document?

A. Yes.

Q. What is that document?

A. This document is an E-mail I sent to Ms. Kathy Perkins, who is a nurse manager at DSHS in

the Department of Regulatory Services. I met her at the Health and Human Services meeting, and she introduced herself to me and gave me her card and suggested, if I had questions along the way about how to comply with the ambulatory surgical center requirements, that she would be more than happy to help me.

This is an E-mail that I sent to her in April, April 21st, 2014, where I sent her information about a mobile ASC unit that I had discovered, which is like a semi-truck, an ASC unit that JCAHO certified and is specifically built for people to bring ambulatory surgical center care to rural communities. It's commonly used by the military as well as hospitals that are under construction, and it seemed like a really good fit for our purposes. I did locate one in Texas that is licensed and being utilized by a hospital in West Texas.

So I contacted her and asked her if she thought of any—I gave her the manufacturer's information in the brochure about the facility and asked her if she thought there was any reason why we couldn't use this to comply with the regulations.

[81] Q. And did you receive a response from Ms. Perkins?

A. I got a response eight days later that said—she apologized for not responding sooner and that she wanted to confirm. She received my E-mail, and she forwarded it to the Office of General Counsel for consideration.

Q. And did you ever get a response from the Office of General Counsel?

A. No, I have not.

Q. Not since April?

A. Not since April, no.

Q. Can you take a look at the document marked Plaintiffs' Exhibit 67

A. Yes.

Q. Are you familiar with that document?

A. I am.

Q. What is that document?

A. This is the brochure for the ambulatory—the mobile ASC unit.

Q. Is that brochure that you forwarded to Ms. Perkins.

A. Yes, it is.

MS. TOTI: Your Honor, Plaintiffs move for the admission of Exhibits 19 and 67 into the record.

MR. STEPHENS: No objection, Your Honor.

THE COURT: Plaintiffs' Exhibits 19 and 67 are admitted. Ms. Toti, how much more do you have?

[82] MS. TOTI: Another 15 minutes, Your Honor.

THE COURT: Mr. Stephens, how much do you think you're going to have on recross?

MR. STEPHENS: No more than 10 minutes.

THE COURT: Well, here's the problem. I'm trying to figure out when to take a break because I have a luncheon meeting that I need to attend away from the Court. So it's going to involve my having to get there. Is this the last witness you-all anticipate today?

MS. TOTI: Yes, Your Honor.

MR. STEPHENS: Yes, Your Honor.

THE COURT: All right. Well, I'm just going to have to inconvenience you and have you come back at 1:30 to finish up. So at this point we will be in recess until 1:30, and then we will finish up today. Thank you.

(Recess)

(Open Court)

THE COURT: Ms. Toti, you may proceed.

MS. TOTI: Thank you, Your Honor.

Q. (BY MS. TOTI) So Ms. Hagstrom-Miller, before the lunch break, we were talking about the efforts of Whole Woman's Health to try to comply with the ASC requirement at issue in this case. Did Whole Woman's Health make any efforts in that regard in McAllen specifically?

A. Yes, we did. Our efforts weren't as broadly focused in [83] McAllen as they were in a couple of the cities where we had privileges already. But even in McAllen, we searched for ambulatory surgical centers that may be for lease or for sale. We did find a property that was not occupied, and it was owned by a group—hospital group called Cornerstone. And we made numerous attempts to get ahold of them—kind of stop by, phone call, E-mail. And then finally when we were able to reach somebody who represented them, we found out that they were Catholic affiliated and not interested in working with us.

Q. And you mentioned, I think, that your efforts may not have been as extensive in McAllen as in other places. Can you explain why?

A. We focused primarily at the beginning on ambulatory surgical centers in areas where we had already secured privileges for at least one or more physicians. And in McAllen we were doing—we were simultaneously trying to secure privileges and also find an ASC. But we were hitting so many roadblocks with the privileges piece, that we focused a little bit more on Fort Worth and Austin where we had some leads that turned up that didn't turn up as much in McAllen.

Q. And can you tell me a little bit about your efforts to obtain admitting privileges for physicians in McAllen—or, rather, I suppose I should say, can you tell me a little bit about your efforts in McAllen to

identify a physician with admitting privileges willing to work for Whole Woman's Health?

[84] A. Yes. We tried lots of different attempts to comply with the admitting privileges requirement in McAllen. We worked on acquiring admitting privileges for our physicians. The physician that did most of the work in McAllen at the time HB 2 was passed was not board certified, and so we didn't spend any time trying to privilege him, because in every hospital that we located within 30 miles of Whole Woman's Health in McAllen, board certification was a requirement.

So we focused on—we found eight hospitals within 30 miles of Whole Woman's Health in McAllen, seven of which had OB-GYN or GYN departments, which is part of the requirement. Every one of those hospitals required a physician who already has privileges at that hospital to serve as a cosigner for the privileges application, so we began looking for physicians who would cosign our applications.

At the same time I began—you know, raised my efforts to recruit physicians to the area as well who may qualify for privileges as I was looking at the—at the requirements. So, one, I was trying to recruit other physicians and, two, trying to recruit local backup physicians at the same time.

Q. And were your efforts to recruit local physicians successful?

A. Not really. So we—in the 11 years of practice with Whole Woman's Health of McAllen, we also purchased the clinic [85] from an OB-GYN who had been in the community for 30 years, and so we had a lot of local physicians who would refer their patients to us and a lot of connectivity in the physician community there.

So we reached out to all of the physicians that had ever referred to us for abortion in that community. We reached out to all of them by letter, inviting them to work with us to help us get privileges. We followed up by phone. We met with at least 10 physicians face to face. And then we were only able to secure one physician who was willing to cosign the application for us.

The physicians had articulated a lot of reasons why they were nervous and directly to me said things like they were worried that they would be—that it would affect their practice; that they would face, you know, stigma within their own OB practice in the hospital; that they may not be able to renew their own privileges; that it may be hard for them to get nurses to scrub in for them; that they may—some physicians were worried about their safety. They cited sort of antiabortion violence and specifically referred to protesters that they had seen at our clinic and were worried that they would attract that attention even cosigning.

And one of the differences is we've had a lot of support in the McAllen community, so we had physicians who were our local backup before. But when you sign on to a hospital [86] application, you've got to put your name down on it and your signature. And that step of being more public made all but one physician too concerned.

So that physician that did agree to be our cosigner had privileges at the Doctors Hospital at Renaissance, so that was the one place where we sent an inquiry letter. It's a hospital that requires you to apply in order to get an application. There's a second level there. So we sent an application—a letter requesting an application for four of our physicians, all of whom were board certified OB-GYNS.

Q. Okay. So you mentioned that you had local backup physicians in McAllen. Can you say a little bit more about what that means?

A. Yes. The requirements of an abortion facility—a licensed abortion facility require that if your physician doesn't have admitting privileges, that you have a working arrangement with a local physician who will take care of your patients if need be. And that is a relationship and an arrangement that's made from physician to physician. We had most of the time two, three, sometimes four physicians in the McAllen community who served as local backup physicians for our facility.

Q. And is it your understanding that that requirement was in effect at the time that HB 2 was enacted?

A. It was in effect up until the time HB 2 was enacted, and [87] then it became that our—the providing physician was required to have active admitting privileges.

Q. And did you in fact meet the requirement of having a local backup physician in McAllen prior to HB 2?

A. Always.

Q. And then I think you just testified that at—at some of the hospitals, including Doctors Hospital at Renaissance, there was a two-step application process; is that right?

A. Yes.

Q. Can you say a little bit more about that?

A. Some hospitals—over the course of trying to get privileges for our physicians in the last six months, we've worked with 48 hospitals in five different cities on behalf of 14 physicians. So there's a lot of different hospital bylaws that we've had to learn. And oftentimes a hospital requires you to formally request an application. So you don't get to apply. You have to apply for—apply to apply. And Doctors Hospital at Renaissance is one of those.

The other hospitals in the Rio Grande Valley area had a very strict policy about the cosigning physician

as well, and we weren't able to get beyond that because we weren't able to recruit a physician who had privileges at any of those hospitals who would cosign.

Q. So did you and staff at your direction review the bylaws for all of the hospitals—the seven hospitals you mentioned [88] within a 30-mile radius of the McAllen clinic that have OB or GYN services?

A. Yes.

Q. And did you rely on the information in those bylaws in making decisions about the application process for the doctors?

A. Yes, we did. We also relied on—most hospitals have, like, a staff department that does privileging. And so there was a lot of conversations with that staff team in addition to the bylaws, you know, where they would tell us what was required and what forms and that kind of thing.

Q. So how—how many physicians who are affiliated with Whole Woman's Health went through the first step of the application process at Doctors Hospital at Renaissance?

A. Four.

Q. And what—what was the outcome of that first step of the application process?

A. All four of those physicians were denied an application. You heard Dr. Lynn testify yesterday. The letter that all four of the physicians received was

received at Whole Woman's Health, and it was identical—the same content in all four letters.

Q. Okay. I'm going to ask you to take a look at Plaintiffs' Exhibit 71?

MS. TOTI: And, Your Honor, this is a new exhibit. This is the one that was created when we broke up Exhibit 68 [89] from yesterday. I believe it is in your binder under tab 71, but it's not yet listed in the list of exhibits at the front of the binder.

Q. (BY MS. TOTI) There are three documents in this exhibit; is that correct?

A. Correct.

Q. All right. So I'm putting the first one up on the screen. Have you seen—have you seen these documents before?

A. Yes, I have. They came to my office.

Q. And what are they?

A. They are the letters that we received from Doctors Hospital at Renaissance explaining why the doctors will not be receiving an application for privileges.

Q. And you said that—that these letters were received by your office?

A. Yeah. The address on here is our facility in McAllen.

Q. And did you review them at that time?

A. Yes.

Q. And did you rely on these letters in concluding that the physicians who had sought applications from Doctors Hospital at Renaissance would not be able to obtain applications from that hospital?

A. Yes, I did.

MS. TOTI: Your Honor, at this time Plaintiffs would like to move Exhibit 71 into evidence.

[90] MR. STEPHENS: No objection, Your Honor.

THE COURT: Plaintiffs' Exhibit 71 is admitted.

MS. TOTI: Thank you.

Q. (BY MS. TOTI) Can you just—can you just take a look at the second paragraph. Is it your understanding that all three of these letters are identical?

A. Yes, they are.

Q. Except for the date at the top and the person to whom they are addressed?

A. Yes.

Q. But in each of these, the physician's name has been redacted?

A. Correct.

Q. But you know who these letters were addressed to, correct?

A. Yes, I do.

Q. And they're physicians—three different physicians that are affiliated with Whole Woman's Health?

A. Yes.

Q. Can you read the second paragraph of the first letter.

A. "The recommendation was forwarded to the Board of Governors for review, and a determination was made not to extend an application to you. Such determination is as authorized under the bylaws and rules and regulations of the medical staff for the hospital. The decision of the governing body was not based on clinical competence consideration."

[91] Q. So did you—do you have an understanding as to whether the request for applications submitted to Doctors Hospital At Renaissance by these three physicians—strike that.

Do you have an understanding about whether the hospital viewed the applicants as qualified for holding admitting privileges as hospital?

A. Absolutely. That's what I would assume when it says it's not based on clinical competence. So the decision was made for a reason other than clinical competence.

Q. All right. I'm all done with the exhibits for now.

A. Okay.

Q. Ms. Hagstrom-Miller, can you tell me what led you to pursue work in the field of reproductive health?

A. Yes. I was drawn to this work because of the—I see it as a human rights issue and did work as an undergrad in international studies and religion and am drawn to it specifically because of the issues of shame and stigma that women experience in abortion care. So I've been working in the field for 25 years.

Q. Are you the founder of Whole Woman's Health?

A. Yes, I am.

Q. Are you proud of Whole Woman's Health?

A. Yes, I am.

Q. Why is that?

A. I—like I said, I've been working in the field a long [92] time and then went out on my own to found my own company a little over 10 years ago specifically to deliver a care model that I believe women deserve that both encompasses medical excellence and also provides a holistic environment where women can come to the facility with their family members and explore, not only the medical decisions, but some of the cultural issues that surround abortion in our country in a safe and supportive environment.

Q. Do you think it's important for Texas women to have access to legal abortion care?

A. Absolutely.

Q. And why is that?

A. You know, women have always needed abortion care just to—to address unplanned pregnancy issues. We had abortions before *Roe*, and since *Roe* we've been able to provide safe abortions. And I think, while nobody gets pregnant to have an abortion, when women face an unplanned pregnancy, they deserve an environment that can give them medically safe care and also compassionate, respectful care delivery.

Q. And was—do you believe that Whole Woman's Health is such an environment?

A. Absolutely.

MS. TOTI: Thank you. No further questions, Your Honor.

THE COURT: Mr. Stephens, recross?

[93] [**RECROSS-EXAMINATION**]

[BY MR. STEPHENS:]

Q. Ms. Hagstrom-Miller, when did Whole Woman's Health Beaumont close?

A. We closed, I believe it was, March 6th, 2014.

Q. And at that time, there were physicians providing abortion services at Whole Woman's Health in Beaumont who had admitting privileges; is that right?

A. Correct.

Q. At the time when the Beaumont and the McAllen clinics closed, what was done with the complication logs for those facilities?

A. They are in storage. As required by the health department, we keep everything for seven years after—after the date of occurrence. So they're in medical record storage along with the patient files.

Q. So they exist?

A. Of course.

Q. They weren't provided to Dr. Grossman?

A. No. Dr. Grossman didn't study the two clinics of ours that had been closed.

Q. Do you know if there's a border patrol checkpoint between the Rio Grande Valley and Corpus Christi?

A. I believe so.

MR. STEPHENS: No further questions, Your Honor.

[94] THE COURT: Ms. Toti?

MS. TOTI: No further questions for this witness, Your Honor.

THE COURT: All right. You may step down.

* * *

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS (AUSTIN)

(Admitted Aug. 5, 2014)

EXHIBIT
P-071
1:14-CV-284-LY

[LOGO]
DOCTORS HOSPITAL AT RENAISSANCE
5501 South McColl Road – Edinburg, Texas 78539

November 4, 2013

[Redacted]
Whole Woman's Health
802 South Main Street
McAllen, Texas 78501

Dear Dr. [Redacted]

The Medical Executive Committee at Doctors Hospital at Renaissance met and reviewed your request for the release of application for privileges for you and your group. The Medical Executive Committee upheld the recommendation of the Credentials Committee to deny your request for application for membership and privileges.

The recommendation was forwarded to the Board of Governors for review and a determination was made not to extend an application to you. Such determination is as authorized under the Bylaws and Rules and Regulations of the Medical Staff for the Hospital. The decision of the Governing Body was **not** based on clinical competence consideration.

Based on the foregoing, applications will not be forthcoming at this time. Thank you for your interest in our Hospital.

Sincerely
/s/ Marissa Castañeda
Marissa Castañeda
Chief Operations Officer

[LOGO]
DOCTORS HOSPITAL AT RENAISSANCE
5501 South McColl Road – Edinburg, Texas 78539

December 2, 2013

[Redacted]
Whole Woman's Health
802 South Main Street
McAllen, Texas 78501

Dear Dr. [Redacted]

The Medical Executive Committee at Doctors Hospital at Renaissance met and reviewed your request for the release of application for privileges for you and your group. The Medical Executive Committee upheld the recommendation of the Credentials Committee to deny your request for application for membership and privileges.

The recommendation was forwarded to the Board of Governors for review and a determination was made not to extend an application to you. Such determination is as authorized under the Bylaws and Rules and

Regulations of the Medical Staff for the Hospital. The decision of the Governing Body was **not** based on clinical competence consideration.

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Sincerely
/s/ Marissa Castañeda
Marissa Castañeda
Chief Operations Officer

[LOGO]
DOCTORS HOSPITAL AT RENAISSANCE
5501 South McColl Road – Edinburg, Texas 78539

November 4, 2013

[Redacted]
Whole Woman's Health
802 South Main Street
McAllen, Texas 78501

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The recommendation was forwarded to the Board of Governors for review and a determination was made not to extend an application to you. Such determination is as authorized under the Bylaws and Rules and Regulations of the Medical Staff for the Hospital. The decision of the Governing Body was **not** based on clinical competence consideration.

Based on the foregoing, applications will not be forthcoming at this time. Thank you for your interest in our Hospital.

Sincerely
/s/ Marissa Castañeda
Marissa Castañeda
Chief Operations Officer

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

Whole Woman's Health, et al., Plaintiffs, v. **David Lakey, M.D.**, Commissioner of the Texas Department of State Health Services, et al., Defendants.	Civil Action No. 1:14-cv-284-LY

DIRECT TESTIMONY OF MAYRA JIMENEZ THOMPSON, M.D.

(Submitted Aug. 6, 2014)

I. Background and Qualifications

1. I am a practicing Obstetrician/Gynecologist in Dallas and serve as an Associate Professor in the Division of Gynecology in the Department of Obstetrics and Gynecology at the University of Texas Southwestern Medical Center. I have served on the medical faculty for 10 years.

2. I received my bachelor's degree from Northwestern University and my doctor of medicine degree from the University of Illinois Abraham Lincoln School of Medicine in 1980. I completed my residency in obstetrics and gynecology at the University of Illinois Research Hospital in 1984.

3. I am board certified in obstetrics and gynecology and am a Fellow of the American Congress of Obstetricians and Gynecologists as well as a member of the Association of Advanced Laparoscopic Surgeons, American Association of Gynecologic Laparoscopists, and the Texas Medical Association.

4. I serve on the active medical staff with admitting privileges at Medical City of Dallas Hospital and North Central Surgical Center in Dallas.

5. I have extensive experience in minimally invasive surgical procedures in the field of gynecology including advanced laparoscopic and robotic surgery, single site laparoscopic and robotic surgery and urogynecologic procedures. I co-authored with Kimberly Kho Chapter 24 entitled "Minimally Invasive Surgery" in WILLIAMS GYNECOLOGY 2nd ed., 2012.

6. I am trained in minimally invasive surgical procedures such as the DaVinci Robot for single-site hysterectomies and have been certified by the International Society for Clinical Densitometry. I routinely lecture and proctor courses for active staff and resident physicians in the use of minimally invasive surgical techniques at UT Southwestern and elsewhere.

7 I am fluent in Spanish and have a special interest in communicating wellness and preventative care in the Hispanic community. I have hosted 2 multiple radio educational shows for the Latin American community not only in Dallas but in the Southwest. Among others, the most well known are "A Su

Salud" and "La Buena Vida." As a result of these efforts, I have been awarded the Female Entrepreneur of the Year Award from the Dallas Hispanic Chamber of Commerce and the "Si Se Puede" award from the Mexican American Professional Women's Association of Dallas. For a complete description of my professional education and experiences, I attach my Curriculum Vitae as Exhibit A.

8. I have not testified as an expert witness at trial or by deposition in the last four years.

9. I will be compensated at the rate of $400 per hour for my work on this case, and $3,000 per day for time spent testifying at deposition or trial. If called to testify, it is my understanding that I will be reimbursed for all travel related expenses by the Office of the Texas Attorney General.

10. I routinely teach medical students and residents and am intimately familiar with abortion services. I am very familiar with ambulatory surgical centers, having performed numerous surgeries there over the past 16 years. I have also served on various hospital committees, including medical staff executive committees, quality assurance, and credentialing and privileges committees. The opinions I express here are mine and not intended to reflect those of the institutions with which I am affiliated.

II. Basis for and Scope of Opinions

11. My opinions expressed herein are based upon my education, training and experience in medicine, including over 16 years providing surgical care in ambulatory surgical centers. In addition, my opinions are based upon my ongoing review of the gynecological/obstetrical literature encompassing sources too numerous to list here in full. Notwithstanding the above, I have consulted the following in forming my opinions:

- American College of Surgeons, *Guidelines for Office-Based Surgery*.2003,p.16.Availableat: http://www.facs.org/ahp/kyOBSguidel2-03.pdf.
- Expert Report of Dr. Paul Fine
- Expert Report of Dr. Elizabeth Raymond
- Expert Report of Dr. Daniel Grossman
- Facility Guidelines Institute, *Guidelines for Design and Construction of Hospitals and Outpatient Facilities*, 2006.
- Guttmacher Institute. "Targeted regulation of abortion providers." *State Policies in Brief*. June 18, 2014. Available at: http://www.guttmacher.org/statecenter/spibs/spib.TRAP.pdf
- Marist Poll, *Abortion in America*, January 2014. Available at: http://www.kofc.org/un/en/resources/communications/marist-poll-abortion-restrictions2014.pdf

- Texas Administrative Code Chapters 135 & 139
- Texas House Bill 2

III. Opinions

12. Plaintiffs oppose select provisions of Texas House Bill 2, referred to in this report as "the Act." Those provisions are: that "a physician performing or inducing an abortion must, on the date the abortion is performed or induced, have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced " and that effective September 1, 2014, the Act requires licensed abortion clinics in Texas to meet the equivalent minimum standards adopted under Texas Health & Safety Code Section 243.010 for ambulatory surgical centers. Act, § 4 (codified at Tex. Health & Safety Code Ann. § 245.010(a)); 25 Tex. Admin. Code § 139.40.

13. Prior to the formation of my opinions, I reviewed the following: H.B. 2, Plaintiffs' Complaint, Plaintiffs' Amended Motion for Preliminary Injunction, and the Expert Reports of Drs. Fine, Raymond & Grossman. The opinions expressed herein may be subject to change given the availability of new information. Hence, it may be necessary for me to revise or supplement my testimony based upon material subsequently presented, and I reserve the right to do so.

14. It is my understanding that the basis of this lawsuit pertains to the closure of two abortion clinics,

Whole Woman's Health – McAllen, and Nova Health Systems d.b.a. Reproductive Services in El Paso, allegedly as a result of the implementation of the Act's admitting privileges requirement.

A. The Surgical Nature & Safety of Elective Abortion

15. Plaintiffs' medical experts (Dr. Fine, Dr. Raymond, and Dr. Grossman) all attest to the safety of legal abortion. However, in my opinion this is not settled science and is premature, especially in light of recent medical research challenging the benefits and safety of this procedure. In my opinion, serious complications and death from abortion are underreported. There is no mandatory federal reporting law and barely half of states have laws requiring abortion complication reporting. Even so, that reporting is inconsistent, likely incomplete, and reflects an undercount due to provider conflicts of interest, definitional problems, and varying enforcement. Furthermore, it is my understanding that deaths due to complications of abortion are often reported under the complication of the procedure (e.g., infection) rather than the procedure itself (induced abortion). Many women having abortion complications present at emergency rooms. They are often unlikely and understandably resistant to acknowledge having had an abortion. Therefore, it is not reasonable to conclude, as Plaintiffs argue, that the health risks of abortion are miniscule compared to childbirth and other medical

procedures. These assertions are based upon faulty and incomplete data compilations and estimates.

16. In his testimony, Dr. Grossman attempts to compare abortion complications by facility type from where the procedures were performed. In doing so, he compares abortion complications from 1 Texas ambulatory surgery center [ASC] with those from 3 Texas non-ASC clinics – all facilities owned by Plaintiff Whole Woman's Health. The findings from his comparative study are suspect and not reliable for a number of reasons: (a) more likely than not, patient characteristics were not equivalent, i.e., younger and healthier patients obtain abortions at non-ASC facilities with higher risk patients going to an ASC, a limitation acknowledged by Grossman; (b) the comparison relies upon speculation, estimations, and recollections from Whole Woman's Health staff, as well as unknown others whose credibility is unreported; (c) facility abortion complication logs were also examined but they may or may not be factual or accurate, particularly in light of this litigation; (d) facility abortion complication logs are likely incomplete and undercount actual complications since the complications identified in the facility logs must obviously be known to the provider and not all women return for a follow-up visit; (e) no independent verification of patient records and complications was undertaken, nor was there any cross validation or linkage to the state mandated abortion complication forms reported to the Texas Department of State

Health Services; and (f) the study and its findings have not been published in a peer-reviewed journal.

17 Dr. Grossman, Dr. Fine, and Dr. Raymond all maintain that surgical abortion need not be performed in an aseptic surgical field and that there is no medical benefit from doing so as this type of sterile precaution is indicated only for a procedure involving an incision into the body. I disagree. Surgical abortion is performed with instrumentation and is indeed an invasive surgical procedure. To the extent abortion is an invasive surgery and has complications including bleeding and infection, the safest operatory environment is a sterile one.

18. In the field of surgery, it is customary to refer to procedures as "minor" or "major" in an attempt to describe the degree or complexity of the procedure and, therefore, follow safety guidelines that are appropriate. According to the American College of Surgeons: "Major surgery" means surgery which requires moderate sedation, deep sedation, general anesthesia, or major conduction blockade for patient comfort. "Minor surgery" means surgery which can be safely and comfortably performed on a patient who has received local or topical anesthesia, without more than minimal pre-operative medication or minimal intraoperative sedation and where the likelihood of complications requiring hospitalization is remote.[1]

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[1] American College of Surgeons, *Guidelines for Office-Based Surgery*. 2003, p. 16. Available at: http://www.facs.org/ahp/kyOBSguide12-03.pdf.

Typically, minor surgeries take place in physician offices, and major surgeries take place in outpatient surgery centers or hospitals.

19. A minor surgical procedure may be a skin biopsy or an incision and drainage of an abscess, which may easily be performed in an office setting. There are few risks and complications for these procedures and they do not warrant performance in a hospital or in an outpatient ambulatory surgical center. Considering the FGI Guidelines,[2] these procedures could be listed under "invasive procedures" because the protective surfaces of the body have been invaded. They are not necessarily excluded due to the emergence of resistant bacteria which could lead to complicated courses.

20. Procedures where a body cavity is entered actively, not passively, are considered invasive and require a different set of standards for safety. The vagina is a natural orifice that is colonized with bacteria, but the cervix and intrauterine cavity are not. The cervix acts as a barrier to the sterile uterine cavity. In order to enter the uterus, which is sterile, to obtain any tissue from within, one must actively or forcibly open the cervix by the use of metal instruments called dilators, thereby breaking the sterile barrier. This is well known to all gynecologists and the risk of perforation into another part of the pelvic

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[2] Facility Guidelines Institute, *Guidelines for Design and Construction of Hospitals and Outpatient Facilities*, 2006.

cavity is serious. In medical training, we stress the importance of recognizing this problem as it may lead to serious infection, hemorrhage or damage to other bodily organs. The actual dilatation is extremely painful due to the nerve fibers located there. Local anesthetics are usually not enough, so the patient requires deeper forms of anesthesia. In a non-pregnant state, this procedure is referred to as a Dilatation and Curettage (D&C) and is traditionally performed in an ambulatory surgical center or hospital.

21. During a D&C, the individuals in the room include the surgeon, a circulating nurse, either a scrub nurse or technician to assist the surgeon, the anesthesia team, a resident, and sometimes a medical student. A D&C begins by anesthetizing and preparing the patient, which includes washing the perineum, the vulva, vaginal area, and lower abdomen. The surgeon scrubs his or her hands and arms, and sterile drapes are placed over the patient to limit contamination of the operative field. The surgeon then inserts a speculum into the patient's vagina, inspects the vagina, and performs a pelvic exam. The surgeon may then use an instrument to grasp and assess the opening of the cervix. If the cervix is not open, the surgeon begins to gently dilate the cervix with the metal dilators. If already open (or once sufficiently dilated), a small probe is inserted to measure the length of the uterus. Dilation continues until the opening is large enough for the surgeon to insert the curette. The surgeon then uses the curette to remove

the tissue. Once the surgeon verifies that the curettage is complete, the tissue is sent to pathology. The surgeon then inspects the uterus for bleeding or other issues. If there is no bleeding or other issue and the patient is stable, the instruments are removed, and the patient may wake up.

22. The non-pregnant uterus has muscular walls that are firm and more resistant to perforation or tear. The pregnant uterus is softer, more easily torn, and more engorged with blood making it more at risk for complications. The further on into the pregnancy, when the fetus is larger, the walls become thinner and easier to damage. The pregnant uterus also contains living fetal tissue which has a membrane barrier in the form of an amniotic sac to protect from infection. This interior space, where the fetus resides, is also sterile unless the membrane is broken or invaded. The pregnant uterus has increased risk of complications when compared to the non-pregnant uterus, not less. Often a diagnostic laparoscopy is performed on a non-pregnant uterus to determine the extent of the perforation if suspected. This can only be done in a surgical suite, not in an office setting. The pregnant uterus with higher risks should only be treated in an ASC or hospital setting where the necessary additional testing or surgery to assess and treat for complications can be safely accomplished. Currently, D&C procedures for non-pregnant women are performed in ASC's or hospital settings due to the need for patient safety. For the most part, traditionally spontaneous incomplete abortions or miscarriages

are treated with a suction curettage, in a manner similar to an elective abortion, in a hospital or ASC. In my opinion, abortion procedures should also be performed in an ASC where the higher standard of care is required so as to better protect the patient's health and safety.

23. Elective abortion for the termination of pregnancy is considered no less safe than a diagnostic or therapeutic D&C. It has comparable risks to the suction curettage for retained products of conception in a miscarriage. These are infection, life threatening hemorrhage, which can lead to hysterectomy, and death. Physicians traditionally perform a D&C in an ambulatory surgical center or hospital due to these risks and to maximize patient safety. In an ASC or hospital setting, the patient is monitored by a licensed medical practitioner and nursing staff who are trained to recognize these risks and complications. To minimize these health risks and perform a D&C in an office setting is, in my opinion, a failure to acknowledge the degree of complexity inherent in this procedure and to accept responsibility for its potential complications – a practice principle stressed to all physicians with basic gynecologic training.

B. The Act Safeguards Patient Health & Safety

24. It is my understanding that the purpose of the Act is to ensure patient health and safety in the event of a serious complication from abortion. By

requiring all abortion providers to obtain admitting privileges at a local hospital and by requiring abortion facilities to conform to the minimum standards of ASCs, the Act addresses the specific needs of patients who may encounter serious abortion complications, not the best interests or convenience of the provider.

25. Not all abortion clinics are the same, nor are abortion providers. Some providers transit in to perform these procedures and then transit out, residing out of state. Plaintiffs argue that if a patient who had an abortion were to have a serious postoperative complication, hospital ERs and hospitalists and/or subspecialists will simply manage the problem, effectively freeing the abortion provider from any responsibility for follow-up or continuity of care (see for example, Dr. Fine's testimony). I do not think this is an accurate or realistic portrayal of patient care in these circumstances. It is my opinion, that communication deficits are common in transfer of care and can lead to delays and a worsened patient condition. Furthermore, in my opinion, to knowingly perform a procedure with known complications, and then be unavailable after that procedure constitutes patient abandonment.

26. As physicians, we have a duty to provide quality care that maximizes our patients' health and safety. The Act assures peer-review of abortion providers by requiring them to be credentialed and hold admitting privileges at a local hospital, thereby protecting patients from less than qualified providers. I have served on hospital credentialing and privileging

committees, am experienced with this process, and know the value of this review and ongoing evaluation of the physician. By requiring abortion clinics to conform to the equivalent minimum standards of ASCs, the standard of abortion care is raised due to the enhanced regulations provided in Texas Administrative Code Chapters 135 & 139.

27. ASCs are monitored for quality assurance, patient safety, and staff and facility compliance via their own internal administrative policies and requirements, as well as by three external mechanisms: state licensure, certification by the federal Center for Medicare Services, and/or accreditation by professional ASC associations or regulatory bodies, including the Joint Commission. Among multiple other requirements, ASCs are routinely monitored for safety standards, including but not limited to incidence of infection, complications, transfers, emergencies, and patient record keeping. This allows for satisfactory monitoring of the outcomes and prediction of compliance.

28. I have practiced in ASC's for over 16 years and am familiar with the standards and requirements set in place to guarantee patient safety. I currently perform essentially the same type of procedures as those used in elective abortion in these locations due to the aforementioned risks as well as to provide my patients with the comfort and reassurance that their welfare dictates. In addition to the actual procedures performed on the day of the surgery, the post-operative check by phone call is initiated

by a registered nurse. The specimens are set for full evaluation by pathology and documentation of the findings. Patients are discharged to home management to be accompanied by a responsible adult of their choosing after minimum criteria for discharge are met as determined by a licensed registered nurse. The physician who performs the procedure must be available 24-7 to address any complications. In the event he or she is unavailable, a designated covering physician must be available for emergency care.

29. Women expect and deserve high quality gynecological/obstetrical care. In my opinion, unregulated abortion care welcomes substandard care and unnecessarily exposes women to serious health risks. On the other hand, when abortion services are closely regulated as through the Act's admitting privileges and ASC requirement, patient protection from adverse outcomes is enhanced and continuity of care is more likely.

30. The admitting privilege requirement of the Act helps ensure that surgeons who perform elective abortions can demonstrate competency. There is longstanding support and acceptance that hospital staff membership and admitting privileges are a key factor in identifying highly qualified and competent physicians. A recent poll identified 73% of Americans strongly support/support such laws.[3] Furthermore, 15 states

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[3] Marist Poll, *Abortion in America*, January 2014. Available at: http://www.kofc.org/unien/resources/communications/marist-poll-abortion-restrictions2014.pdf

have enacted laws equivalent to Texas requiring abortion providers to have some affiliation with a local hospital, and 27 states require abortion clinics to meet ambulatory surgical standards.[4] The credentialing process essentially reviews documentation of provider education, training and experience prior to receiving hospital staff privileges to perform procedures. This includes preoperative, intraoperative and post-operative care.

31. Intraoperative safety specifications traditionally used in most operative suites in ASCs or hospitals are emplaced to prevent adverse outcomes. With ASC minimum requirements replacing abortion clinic standards, abortion facilities will then meet the same criteria that other outpatient surgeries must meet rather than having their own separate standards. Even if this results in fewer abortion facilities in Texas, the higher standard of care at ASCs is more advantageous for women's health and safety.

32. Continuity of care is a routine standard of care in medicine, and abortion services should not be an exception. When a physician performs an elective abortion, he or she is the most knowledgeable about the procedure and the patient. He or she is also the one responsible to treat the patient in the event of a complication or adverse event. Dr. Fine indicated at

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[4] Guttmacher Institute. "Targeted regulation of abortion providers." *State Policies in Brief*. June 18, 2014. Available at: http://www.guttmacher.org/statecenter/spibs/spib.TRAP.pdf.

¶ 29 that the emergency room physician will assume responsibility for the care of the patient suffering a serious abortion complication. Accordingly, the abortion provider can discharge his responsibility for continuity of care by simply making a telephone call to the ER physician. In my opinion, this constitutes patient abandonment. The ER physician has no prior relationship with the abortion patient and is unfamiliar with her medical history and personal preferences. If an on call gynecological specialist is requested, delays, lack of communication or miscommunication can occur, needlessly exposing abortion patients to increased health and safety risks. Continuity of care allows one to use phone consultation as part of follow up care, but it does not release the surgeon from the responsibility to perform any surgical intervention or hospital treatments in the event of complications. The sole exception would be a situation where the patient elects freely and independently to travel far from the doctor's practice.

C. Other Opinions

33. It has been my clinical experience over 30 years of practice, as well as the experience of many of my colleagues that abortion providers rarely if ever communicate to accepting providers about patients sent to hospitals with complications resulting from abortion. I have personally taken care of patients who have been admitted with complications following abortion procedures and can say that I do not ever remember being contacted by an abortion provider to

give me information about the patient or the procedure which he/she performed. This is not continuity of care, but discontinuity of care. Failure to communicate and provide for continuity of care on the part of a physician in the ambulatory surgery centers and hospitals where I practice would trigger an accountability review before hospital peers, and likely result in disciplinary action for patient abandonment and irresponsible care.

34. It has been my experience, and based upon my contacts with colleagues performing surgeries in ambulatory surgical centers, that these surgeons already maintain local hospital admitting privileges. Thus, the Act is not discriminatory against abortion providers, but rather requires them to perform at this higher standard of care which is optimum for a woman's reproductive health and safety.

35. And finally, in my medical opinion, a competent and well trained abortion provider would have no difficulty in obtaining hospital privileges. To me, not pursuing such privileges demonstrates a lack of interest or commitment on the physician's part to providing the highest quality care to women seeking abortion services. Indeed, prior to H.B. 2, a number of Texas abortion providers held and continue to hold admitting privileges thereby supporting my opinion.

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

Whole Woman's Health, et al., Plaintiffs, v. **David Lakey, M.D.**, Commissioner of the Texas Department of State Health Services, et al., Defendants.	Civil Action No. 1:14-cv-284-LY

DIRECT TESTIMONY OF JAMES ANDERSON, M.D.

(Submitted Aug. 6, 2014)

I. Background and Qualifications

1. I received my M.D. from the University of Virginia, School of Medicine in 1978. I have been board certified in Family Practice since 1981 and board certified in Emergency Medicine since 1996 by the American Association of Physician Specialists. I have been certified in Advanced Trauma Life Support since 1992 and in Advanced Cardiac Life Support since 1984.

2. I am a Clinical Professor in the Department of Family Medicine & Population Health at Virginia Commonwealth University School of Medicine, having

served on the clinical faculty since 1995. In 2002, I joined the U.S. Army Reserves. In 2005, I resigned from U.S. emergency rooms due to the time demands of my military responsibilities and have served in the emergency departments of the U.S. Army's Combat Support Hospitals (CSH) while deployed to Iraq in 2007 and 2009. In 2011, I served in the out-patient department at Craig Hospital at Bagram Airfield, Afghanistan and held the rank of Colonel, USAR. I was discharged from the USAR in September 2012, when I turned 60 years old.

3. I am board certified in Family Practice as well as in Emergency Medicine, and for 22 years I have been an Emergency Room Physician in the Commonwealth of Virginia.

4. Over the last three decades, I have treated many patients who arrived at U.S. emergency rooms and U.S. military hospitals extremely sick including critical situations of hemorrhage and infection. I have also treated patients who have experienced serious complications from an abortion and required emergency room management. For a complete listing of my professional activities, please see my attached Curriculum Vitae. (Exhibit A)

5. In the past four years, I have testified as an expert witness, either at trial or by deposition, in the following cases:

- Expert Witness for Defendants. *Planned Parenthood of the Great Northwest et al., v State*

of Alaska. Case No. Civ. 3AN-10-12279 CI, Anchorage, Alaska, 2000.

- Expert Witness for Defendants. *Planned Parenthood Southeast et al., v. Strange, et al.* Case No.: 2:13CV405-MHT. Montgomery, Alabama, 2013-14.
- Expert Witness for the Defendants. *Planned Parenthood Wisconsin et al. v. Van Hollen et al.* Case No. 13CV465. Madison, Wisconsin, 2014.
- Expert Witness for the Defendants (by declaration), *Planned Parenthood Of Greater Texas Surgical Health Services V. Abbott.* Case No. 1:13-cv-862. Austin, Texas, 2013

6. My consultation fees are $300 per hour and $3,500 will be charged per day for time spent testifying either in deposition or at trial. My understanding is that all travel related expenses are also paid for by the State of Texas.

II. Basis for Opinions

7 I provide the following facts and opinions as an expert in family medicine and emergency medicine. I am familiar with abortion complications and their treatment and experienced with emergency medical services and transfers of care. The opinions I express here are based upon my years of experience in the fields of family medicine and emergency medicine, my teaching and clinical experience, my

treatment of abortion complications, and my familiarity with the medical literature.

8. My opinions expressed herein are based upon over three decades of medical experience, including over 22 years as an emergency room physician. Medical articles and reports I have considered are provided below, and while informative, they are not the sole basis of my opinions. In addition, my opinions are based upon my ongoing review of the medical literature encompassing sources too numerous to list here in full. My opinions are not based solely upon one study or subset of studies, but rather upon the integration of my medical training, clinical experience, and related medical literature. Notwithstanding the above, I have consulted the following in forming my opinions:

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July 11, 2013. Available at: http://rhrealitycheck.org/article/2013/07/11/for-decades-authorities-let-rogue-abortion-provider-harm-women-despite-pleas-from-legitimate-doctors/

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- Jones, R. & Kost, K. "Abortion in the United States. An analysis of the 2002 National Survey of Family Growth." *Studies in Family Planning*, 2007, 38:187-197
- Kessler CS, et al. "A prospective, randomized, controlled study demonstrating a novel, effective model of transfer of care between physicians: The 5 Cs of Consultation." *Academic Emergency Medicine*, 2012, 19:969-974.
- Mandel & Pavlesky. "Treatment of Severe Hypovolemia or Hypovolemic Shock in Adults." *UpToDate*, 2013, p. 1.
- Moorman, D.W. "Communication, teams and medical mistakes." *Annals of Surgery*, 2007, 245, 173-175.
- National Research Council – Institute of Medicine. To *Err Is Human: Building a Safer Health System.* Washington, D.C.. The National Academies Press, 2000. Available at: http://www.nap.edu/catalog.php?record_id-9729.

- Neviere, R. "Sepsis and the systemic inflammatory response syndrome: Definitions, epidemiology, and prognosis" *UpToDate*, 11/14/2013, p. 1.
- O'Daniel, M. & Rosenstein, A.H. "Professional communication and team collaboration," Ch. 33, in Hughes, R.G. (Ed.) *Patient Safety and Quality.* Rockville, MD: Agency for Healthcare Research and Quality, 2008.
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- Petersen, L.A. "Racial differences in trust: Reaping what we have sown? *Medical Care*, 2002; 40:81.
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III. Opinions

9. It is my understanding that Plaintiffs oppose select provisions of Texas House Bill 2, referred to in this report as "the Act." Those provisions are: that "a physician performing or inducing an abortion must,

on the date the abortion is performed or induced, have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced " and that effective September 1, 2014, the Act requires licensed abortion clinics in Texas to meet the equivalent minimum standards adopted under [Texas Health & Safety Code] Section 243.010 for ambulatory surgical centers." Act, § 4 (codified at Tex. Health & Safety Code Ann. § 245.010(a)); 25 Tex. Admin. Code § 139.40.

10. In my expert opinion, the above provisions of the Act are reasonable and medically necessary to protect the health and safety of Texas women. Furthermore, it is my opinion that these regulations will both improve the quality of abortion care offered in abortion clinics and improve the postoperative management of serious post-abortion complications. As I understand it, the purpose of the Act is not to limit abortions but to help ensure a higher standard of care for women having an abortion. In a patient-centered health-care system the top priority is patient safety with the best possible clinical outcomes

11. Foundational principles of a patient-centered health-care system include doctor-patient trust, communication, and continuity of care. This Act will help improve all three areas. Despite what Dr. Fine (¶ 2) and Dr. Raymond (¶ 2) argue about the lack of evidence-based medical support for this Act, it has been clearly shown that these foundational principles undergird quality patient care and are associated with

better clinical outcomes. As cited later in this report there is clear evidence that these foundational principles of a patient-centered health-care system all contribute to patient safety and better clinical outcomes. Along with this evidence, it is beyond question that patients expect their surgeon to be competent and provide care in the safest manner possible. Plaintiffs' experts, Drs. Fine, Raymond and Grossman, all discount the long-standing value of hospital credentialing and privileging and provide no reasonable or objective alternative method to evaluate a physician's credentials and competency. Without which, patients are needlessly exposed to unqualified physicians and unnecessary health care risks. In my opinion, patients would also reasonably reject the option of having their surgeon travel in (often from out of state) for their procedure and then travel out of the area on the same day,[1] increasing the likelihood of their being unavailable and inaccessible for post-operative complications. This lack of accessibility and availability is all too likely to reduce communication with other physicians.

12. These foundational principles of doctor-patient trust, communication and continuity of care,

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[1] Dr. Fine has previously testified in a related admitting privileges case in Alabama that nationwide one out of four Planned Parenthood abortion facilities employ out of state abortion provides. See: Deposition of Paul M. Fine, M.D., Planned Parenthood, et al. v. Stave, et al., 2:13-cv-405-M HT, October 29, 2013, p. 15.

are taught at the very beginning of the medical education by all U.S medical schools. In order to graduate, all medical students must pass a supervised patient encounter. The osteopathic students call it the Comlex-PE. The allopathic students call it the OSCE. All the medical students are graded on taking a history and performing a physical exam on a patient. In this process they are graded not only on their technical physical exam skills but are also graded on their communication techniques and their methods to develop a relationship connection with the patient. I cannot understand why Drs. Fine and Raymond would advocate a health-care system that diminishes these foundational principles with this particular patient population of vulnerable, pregnant women. This group of women need and deserve well trained physicians who are qualified, accessible and communicative.

13. While the majority of first trimester abortion complications may be able to be handled as outpatients, the Act helps ensure a better standard of care for those who have serious enough complications as to need hospital care. This group of patients is the sickest and needs specialized care that is timely in an atmosphere of good communication. This is precisely what the Act addresses and will help ensure.

14. There are three reasons the Act improves patient safety and clinical outcomes:

a. The hospital credentialing and admitting privileges requirement of this Act results in the

rigorous scrutiny of both a doctor's qualifications and his/her technical skills required for surgical procedures. This credentialing process also exposes physicians whose patient-care track record is suspect and may need remediation.

b. The Act improves doctor-patient continuity of care because hospital staff privileges mandate standards of accessibility and availability of the doctor. This accessibility and availability improves continuity of care which is directly related to patient safety and clinical outcomes.

c. The accessibility and availability of the doctor as required by the staff privileges also improves physician to physician communication. This reduces communication errors and costly time delays and thus improves patient safety and clinical outcomes.

15. It is my understanding that as of 2004 Texas required abortions at 16 weeks LMP or greater to be performed in ambulatory surgical centers ("ASCs") (See: Texas Health & Safety Code § 171.004). At the time, multiple allegations of clinic closures were made. Today there are six ASCs in Texas performing abortions, and more scheduled to open.[2] According to

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[2] "Planned Parenthood South Texas has announced plans to build a new $5 million ambulatory surgical center in San Antonio " See: Grimes A. "Planned Parenthood Announces Plan to Build New Surgery Center in Texas." RH Reality Check, April 3, 2014, available at: http://rhrealitycheck.org/article/2014/04/03/planned-parenthood-announces-plan-build-new-surgery-center-texas/; and the Texas Women's Reproductive Health Initiative plans on building two new licensed and accredited ambulatory surgical

(Continued on following page)

the most recent online data available, 22.4% of all in-state abortions for Texas residents were performed in ASCs.[3] When abortion is performed at these facilities, I understand Texas previously required either that the physician performing the procedure must have admitting privileges or have a working arrangement with a physician who has admitting privileges at a local hospital (*See*: 25 Texas Admin. Code § 139.56). The Act replaces this regulation by eliminating the less safe option of transfer of care to another physician with admitting privileges, and extends the admitting privileges requirement to all physicians performing abortions in Texas. Currently, 15 states require abortion providers to have some affiliation with a local hospital, 5 states require providers to have admitting privileges, and 9 states require providers to have either admitting privileges or an alternative arrangement, such as an agreement with another physician who has admitting privileges. Twenty-seven

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centers in Houston and Dallas in 2014. According to the website: "In compliance with Texas Department of Health's requirements, our dedicated Ambulatory Surgery Centers will allow access to high quality reproductive health services for all Texas residents." Available at: http://TWRHI.org.

[3] Table 38: Selected Characteristics of Induced Termination of Pregnancy Texas Residence – 2012. Texas Department of State Health Services, Center for Health Statistics. Available at: https://www.dshs.state.tx.us/chs/vstat/vs11/t38.shtm.

states require abortion facilities to meet structural standards intended for ambulatory surgical centers.[4]

A. Abortion Safety: Concern for Credibility of Data

16. Plaintiffs' medical experts all attest to the safety of surgical and medical abortion (Dr. Fine Expert Report at ¶ 15, Dr. Raymond Expert Report at ¶ 6, and Dr. Grossman Expert Report at ¶ 22). It is my understanding that the data upon which these assertions are based are incomplete and unreliable.[5]

17 In my experience as an Emergency Room physician for over twenty-two years. I have seen numerous complications of abortion and have often wondered about the low complication rate that was reported in the literature. When I went to Virginia's Bureau of Vital Statistics, I discovered that Virginia has no numbers on abortion-related complications. Even though I was surprised, this was consistent with my experience and the experience of my Emergency Room colleagues. Never once had I reported a complication of abortion to the State of Virginia even though in my career I have taken care of many patients who

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[4] Guttmacher Institute. "Targeted regulation of abortion providers." *State Policies in Brief*. June 18, 2014. Available at: http://www.guttmacher.org/statecenter/spibs/spib_TRAP.pdf.

[5] Thorp, J. (2012). Public health impact of legal termination of pregnancy in the US: 40 years later. **Scientifica**, Article ID: 980812, 16pp. Available at: http://dx.doi.org/10.6064/2012/980812.

have suffered an abortion related complication. The State of Virginia neither requires the reporting of these complications nor do I know of any process in place where I could do it voluntarily other than to register a complaint about a violation of the standard of care. Virginia is not alone.[6]

18. My experience is not an exception. My Emergency Room colleagues and other physicians I have spoken with have similar experiences. As an example, Chippenham Hospital in Richmond, Virginia, had over 92,000 Emergency Room visits in 2012. Chippenham Hospital's ER is the second busiest ER in the State of Virginia. I inquired of my former ER director, who has worked full-time in this ER since 1981, "how many abortion-related complications had he ever reported?" In thirty-two years he

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[6] According to the Guttmacher Institute as of June 1, 2014, some 27 states require reporting of abortion complications. Those states which do not are: Alabama, Alaska, Arkansas, Colorado, Delaware, District of Columbia, Florida, Iowa, Kansas, Kentucky, Maine, Massachusetts, Nevada, New Hampshire, New Jersey, New Mexico, South Carolina, Tennessee, Texas, Vermont, Virginia, and West Virginia. See: *State Policies in Brief*. Abortion Reporting Requirements. Available at: http://www.guttmacher.org/statecenter/spibs/spib_ARR.pdf. The above compendium contains two errors which I am aware: it omitted California (it does not provide data to the CDC) and included Texas. It is my understanding that Texas has required the filing of abortion complications since 2012. This statewide data only captures complications known to the physician reporter, including abortion provides. If patients with complications do not communicate with their provider, this data is not reported nor captured by the Texas Department of State Health Services.

said he has never reported one such patient to the State of Virginia even though he also has taken care of many such patients. I asked another full-time ER physician the same question. He had practiced in Pennsylvania until moving to Virginia in 2006. He too had not reported a single patient who suffered an abortion-related complication to Pennsylvania or Virginia health departments, even though he had taken care of many such patients as well. Plaintiffs and their experts all allege the safety of abortion, yet my experience with patients who have post-abortion complications and with Virginia's lack of data collection make me question the accuracy of their data.

19. Another reason from my experience that makes me wonder about the data on post-abortion complications is that many of my Emergency Room patients who had post-abortion complications and were reticent to acknowledge having had an abortion. I have had many patients request that I conceal the fact that they had an abortion as part of their medical history, both recent and even abortions from years prior. I have had patients ask me to use the diagnosis of infection or vaginal bleeding without using the word abortion in the admitting diagnosis. If these charts were reviewed for data-collection purposes, it would be difficult to easily identify which ones were a post-abortion complication.

B. Advantages of the Hospital Staff Privileges Law: A Thorough Evaluation of Physician Qualifications and Technical Surgical Skills

20. The hospital credentialing and admitting privileges requirement of the Act results in the rigorous scrutiny of a doctor's qualifications and brings regular review of technical surgical skills. The training and subsequent credentialing of doctors has been a time-proven method to ensure that those doing life-impacting surgical procedures are qualified to do so. This translates to better patient safety and better clinical outcomes. Dr. Larry Kachik, Joint Commission Surveyor said, "The credentialing of a new applicant is an arduous process that demands meticulous attention to detail from all parties involved. When performed thoroughly and objectively, it may be the most important factor in improving patient care and safety."

21. If a physician cannot obtain admitting privileges because of insufficient training or because of a track record of poor patient care, then in my medical opinion, the physician is not qualified to do the surgical procedures that have life-changing or life-threatening impact. Dr. Kermit Gosnell and Dr. Steven Brigham are two notorious examples of doctors who did not hold hospital privileges and have lost their medical license because of the injuries that they caused to many of their patients. The hospital credentialing process would have bought focus to their poor technical skills and poor patient-care track record

and would undoubtedly have saved many women much physical and emotional heartache. Drs. Fine, Raymond and Grossman do not address this issue of how to protect this vulnerable patient population from poorly qualified physicians. They attest to the safety of abortion but do not adequately address this equally important issue of a physician's qualifications and patient-care track record. Dr. Raymond asserts in her Expert Report at ¶ 35: "while medical facilities are expected to have mechanisms in place to ensure that physicians are qualified to perform the procedures that they provide and that patients experiencing medical emergencies will be swiftly and safely transported to a hospital, admitting privileges at a local hospital are not part of accepted medical practice and are not needed to ensure safety of medical and surgical procedures in outpatient settings." In Richmond, Virginia, the ambulatory surgical care center where I refer my patients requires its physicians to have admitting privileges as part of employment there. This admitting privileges requirement provides a non-biased evaluation of the physician. Dr. Raymond does not explain how an abortion facility in Texas would provide this same non-biased evaluation when there clearly exists a conflict of interest when hiring physicians who might be poorly qualified because of a perceived shortage of abortion providers.

22. A tragic example of the need for hospital credentialing and admitting privileges is that of Dr. Nicola Riley. She remains licensed to practice medicine in Utah, but not in Wyoming (she voluntarily

surrendered her license because of threatened board revocation) and Maryland (her license was permanently revoked). Along with Dr. Steven Brigham, she would transit in from Utah, perform late-term abortions in Elkton, Maryland, and then return to Utah where she also practices and resides. Though licensed in Maryland at the time, she held no admitting privileges there. While being supervised by Dr. Brigham, Dr. Riley performed a late-term abortion on an 18 year old woman and ruptured her uterus and perforated her bowel. Dr. Riley's license to practice medicine in Maryland was irretrievably revoked for failing to have an emergency plan for complications at the Elkton abortion clinic, failing to call for emergency help for at least an hour and a half after perforating her patient's bowel during the procedure, and for transporting her critically injured patient to a nearby hospital in the back seat of a car, thereby compromising the life and safety of her patient. The Board found Dr. Riley's decision and complication management was "not only flawed, life-threatening and unprofessional, but showed poor clinical judgment."[7] Even though Dr. Riley lost her medical license in Maryland, she is still able to practice her substandard medical care on unsuspecting patients in Utah[8]

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[7] Final Decision and Order of the Maryland State Board of Physicians in the matter of Nicola I. Riley, M.D. Available at: http://www.mbp.slate.md.us/BPQAPP/orders/D7121305.063.pdf.

[8] Utah Division of Occupational and Professional Licensing, Medical License # 5665820-1205 – status active. *See*: https://secure.utah.gov/llv/search/detail.html?license_id=3934882. After reviewing

(Continued on following page)

because she is not required to be evaluated by a hospital's credentialing process. From this example, it is clear that Utah's licensing protocol alone is insufficient to fully protect its patient population.

23. It is my opinion that the higher scrutiny that hospital credentialing and privileging processes provides would far better protect abortion patients if they experience complications rather than unknowingly relying upon physicians whose abortion practice may be substandard and negligent and who have no hospital privileges.

24. Obtaining admitting and staff hospital privileges is a careful and considered process. The most prominent entity overseeing these steps is the Joint Commission (TJC) through its hospital accreditation process which is very thorough, precise and demanding. Its review process includes examining requirements for credentialing and continuing education of hospital staff, all under the umbrella of patient care and advocacy. In 2008 TJC added two significant standards into their hospital accreditation guidelines for physician competency-based privileging: the Ongoing Professional Practice Evaluation (OPPE) and the Focused Professional Practice Evaluation (FPPE). These required hospital accreditation criteria mandate

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the actions of the Maryland and Wyoming Boards, the Utah Board elected to only publically reprimand Dr. Riley, require her to write an essay on emergency practice, and fine her $5,000 pending the outcome of her Maryland appeal. *See*: http://dopl.utah.gov/orders/2013-247_SA_2013-11-25.pdf.

focused and careful determination and review of physician competency.[9] Maximizing patient safety and health is the number one responsibility of the health-care system. Requiring abortion providers to undergo peer review through the local hospital's credentialing process is a standard which is reasonable and appropriate given the gravity and uniqueness of the nature of abortion, and the potentially life-threatening complications that can result for the woman.

25. In my experience, hospital credentialing is generally a more rigorous screening and evaluation of a physician than the process of obtaining a state medical license. Both state licensing and hospital staff credentialing require proof of education, letters of recommendation, records of continuing medical education and questions about prior malpractice or disciplinary action from prior regulating agencies. Generally however, only hospital staff credentialing requires reporting the number of past procedures performed to verify the experience and training necessary for these specific procedures. Only by reviewing and evaluating this information is the hospital able to verify that the physician has sufficient training and experience to perform the requested procedures. Hospital staff privileges are dependent on this review; so is quality patient care. Since most, if not all hospitals

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[9] Hunt JL. "Accessing physician competency: An update on The Joint Commission requirement for ongoing and focused professional practice evaluation." *Advanced Anatomy & Pathology*, 2012, 19:388-400.

require credential and licensing review every two years, this too helps maintain a quality medical staff and quality patient care. Renewing the medical license in most states, if not all, is only a matter of paying the set fee required by the particular state. In summary, the hospital credentialing process is protective of patient care but not restrictive or onerous for the physician.

26. While some hospitals may require a certain number of admissions per year in order for a physician to obtain admitting privileges, most have different categories of admitting privileges, i.e., courtesy and temporary, to accommodate those physicians who have infrequent admissions. For example, in the two local hospitals where I have had staff privileges since 1979, courtesy staff privileges meet the credentialing requirement of medical staff privileges but do not require a minimum number of admissions, nor the participation in staff-related administrative responsibilities.[10] It has been my experience that hospitals do try and accommodate physician staff privilege requests once the physician has demonstrated training/experience and clinical competency. In special circumstances hospitals have different medical staff classifications that allow for patient care without certain

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[10] A courtesy staff appointment generally refers to a physician who meets the qualifications for appointment to the medical staff but who admits patients to the hospital only occasionally or acts only as a consultant. Such a physician is typically ineligible to vote or otherwise participate in medical staff activities.

other staff requirements, i.e., committee assignments, minimum number of admissions, residence, or taking un-referred call.

27 The hospital credentialing process is also needed because of the financial potential that exists for abortion providers. Plaintiffs have said repeatedly that there are a limited number of physicians willing to provide abortions. This combination of a high income and a limited number of physicians willing to do abortions creates a potential for Texas' TOP clinics to hire unqualified and insufficiently trained physicians. This situation warrants careful state scrutiny and regulation. In my opinion, hospital credentialing acts as another layer of protection for patient safety. The limited number of abortion providers in no way justifies a system that allows for poor or substandard care to women.

C. The Act Conforms to Foundational Medical Principles Critical to Good Healthcare Delivery

28. Requiring hospital admitting privileges of physicians who perform abortions is much more than a mere regulation. This Act supports medical principles that are related to better healthcare outcomes for patients who undergo an elective abortion because these principles are foundational and critical to all good healthcare delivery. As stated earlier in this report, they are: doctor-patient trust, communication, and continuity of care. These foundational principles

undergird quality patient care and are presumed to exist throughout the healthcare system. Not only are these principles tied to better patient outcomes and patient safety, but, in my opinion, they are also what every patient would choose to have. I believe all patients should have the benefit of these foundational principles in their healthcare, particularly patients facing an undesired pregnancy.

29. These foundational principles are considered very important to the American Committee of Graduate Medical Education (ACGME) and to the Residency Review Committees (RRC) that oversee all graduate medical education, i.e., the residencies that train the future physicians in different subspecialties. The ACGME and RRC's have developed a list of core-competencies that every Residency program across America must implement and measure in the training of each physician. These core competencies are professionalism, patient-care, interpersonal and professional communication skills, medical knowledge, practiced-based learning and system-based practices. These core competencies are considered to be essential to good healthcare delivery and good patient outcomes. In my opinion, the Act is consistent with the core competency priorities and focus of the ACGME and RRC's. Within these core competencies the development of doctor-patient trust, communication and continuity of care are taught, emphasized and regularly evaluated throughout the residency training. Each training physician is expected to become proficient with these aspects of the core competencies.

30. The training that emphasizes the importance of the doctor-patient relationship occurs throughout the residency training of physicians. This is so fundamental to a good healthcare system and good patient outcomes that this emphasis actually begins in the very first year of medical school. For over a decade, I have been involved in teaching a first-year course at the Virginia Commonwealth University Medical School entitled "Foundations of Clinical Medicine" (FCM). We spend the whole year on the doctor-patient relationship, effective communication, patient value and dignity, and medical thinking and processing. Lectures during the first year include titles such as "Students will describe professional, personal, and patient-focused benefits of an effective Dr/Pt relationship" and "Creating a Beneficial Doctor-Patient Relationship ("They're REALLY smart, but I don't think they're a very good doctor")."

31. At the very center of good healthcare delivery is the relationship between the doctor and the patient that involves trust. Trust is an investment into someone's character, their knowledge base and their technical skills. With trust there is always a vulnerability, sometimes tremendous, which can be the doorway into healing, as in life-threatening elective heart surgery, or tremendous exploitation, as in charlatan medical practices. Trust is the subterranean dynamic that enables a patient to follow a safe plan in the midst of uncertainty and fear. In a good healthcare system, the dynamic of trust is essential to guide and direct patient care for the good and benefit of the

patient. Every patient desires and is entitled to trust in his/her doctor-patient relationship. This dynamic of 'trust' has been shown to be a "crucial element in the therapeutic alliance between patient and health care provider. It correlates directly with adherence to physician recommendations and patient satisfaction."[11]

32. The relationship of trust between physician and patient has long been recognized as critical to good care. It is basic in medical education that clinicians must build and sustain trustworthy relationships in order to hear and grasp patient concerns, elicit their requests, negotiate diagnostic and treatment strategies, teach them about their health or illness, check on adherence to treatment plans, and assess the outcomes of interventions. In my opinion, in the absence of the Act, if the state does not require a good credentialing process and follow-up responsibility, then the state is de-emphasizing and diminishing the fundamental value of the relationship between the abortion providing physician and the patient.

33. When focusing on the particular patient group involved here, it is reasonable to assume that many and perhaps most of these pregnant women are

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[11] Petersen, L.A. "Racial differences in trust: Reaping what we have sown? *Medical Care*, 2002; 40:81; Thom, D.H. & Campbell, B. "Patient-physician trust: an exploratory study." *Journal of Family Practice*, 1997; 44:169.

especially vulnerable given their circumstances. Many women with an undesired pregnancy may perceive their situation to be desperate and feel they are without the financial means to choose between alternate options. Many may feel pressured or coerced to abort or feel overwhelmed by fear and anxiety over the future.[12] They often must trust a physician they do not know and hope that their trust is well-placed. It is in the best interests of these patients in particular to have a competent and peer-reviewed healthcare provider whose patient care is held accountable through hospital credentialing and privileging.

34. Physicians are generally held to a high standard of competency in almost every area of medicine through licensure, hospital credentialing and regulatory oversight which protects and strengthens the public's trust in the healthcare system and patient safety. Presently this high standard of competency is not consistently provided to this very vulnerable patient group, i.e., women with an undesired pregnancy. Because of the high standard of care mandated in other areas of elective surgical procedures, this foundational 'trust' in the healthcare system is more likely to make the pregnant women seeking an abortion

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[12] Hall, M., Chappell, LC, Parnell, BL, Seed, PT & Bewley, S. Associations between intimate partner violence and termination of pregnancy: A systematic review and meta-analysis. *PLOS Medicine* Jan. 2014, 11(1): e1001581. Available at: http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001581.

more vulnerable to exploitation if they wrongly assume abortion-providing physicians are held to the same standards as other physicians. Specifically, patients seeking abortion may assume that: (a) their abortion provider's credentials have been thoroughly evaluated; (b) their abortion provider will be available if a complication develops; and (c) there will be good communication between physicians in the event of medical complications. Texas patients are likely to believe that these assumptions are part of elective abortion services because they are the norm in other areas in their state's healthcare system.

35. Texas has supported an education and proficiency standard-of-care expectation of physicians that has sustained a strong patient-doctor trust relationship. This correlates with good patient satisfaction and better patient outcomes in almost every area of medicine. It is inconsistent to promote and advocate for a strong patient-doctor trust relationship in all areas of medicine except in the care of women terminating their pregnancy. If the state continues to allow physicians performing abortions to avoid hospital credentialing and privileging and not be available for follow-up after elective surgical complications and not be required to communicate with other physicians in the transfer of care, then, in my opinion, the state is allowing this very vulnerable group of pregnant women to be exploited. Pregnant women will assume that the same standards of care will exist in elective abortions as in other outpatient surgical procedures.

In this case, more likely than not, their trust is misplaced.

D. Advantages of Local Hospital Admitting Privileges Provision: Improving Continuity of Care

36. Continuity of care pertains to physician availability, reliability and perseverance rather than abandonment. Continuity of care involves knowing particulars about patients that influence future medical decisions, such as allergies, past medical-surgical procedures and chronic disease states and the responsibility to convey this important information accurately and sufficiently for others to continue care. The Act ensures greater accountability for the physician performing the abortion to be involved in post-abortion complications rather than being unavailable after the procedure which is the case when abortion providers come in from out of town and leave the same day of the abortion. The unavailability of abortion physicians not only makes continuity of care nearly impossible, it also undermines trust rather than builds it, and is inconsistent with the assumptions and expectations of vulnerable patients undergoing this elective procedure.

37 There are three major components of continuity of care: *informational continuity*, i.e., formally recorded information is complemented by tacit knowledge of patient preferences, values, and context that is usually held in the memory of clinicians with whom

the patient has an established relationship; *management continuity*, i.e., shared management plans or care protocols, and explicit responsibility for follow-up and coordination, provide a sense of predictability and security in future care for both patients and providers; and *relationship continuity*, i.e., built on accumulated knowledge of patient preferences and circumstances that is rarely recorded in formal records and interpersonal trust based on experience of past care and positive expectations of future competence and care.[13] While the current focus on increasing access makes it more difficult for patients to see the same doctor, the relationship between doctor and patient is central to good care. Neither information nor management continuity directly substitutes for relationship continuity.[14] There is good evidence to support the assertion that patients are more satisfied when they see the same doctor.[15]

38. Dr. Fine states in his Expert Report at ¶ 29: "Continuity of care can be maintained by direct telephone communication between the abortion provider and the emergency room physician; it is not

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[13] Guthrie B., Saultz, JW, Freeman, GK. Continuity of care matters. *British Medical Journal* 6 Sept. 2008, 337:548-549. Available at: http://www.commed.vcu.edu/IntroPH/Primary_Care/2008/Continuity.pdf.

[14] Ibid.

[15] Ibid., citing Saultz, JW, Albedaiwi, W Interpersonal continuity of care and patient satisfaction: A critical review. *Annals of Family Medicine* 2004; 2:445-451.

dependent on whether the abortion provider has admitting privileges. Such direct telephone contact is standard medical practice and serves to ensure that the emergency room physician is aware of the extent of the complication, prior treatment, and medication received." From this statement it is clear that Dr. Fine's definition of continuity of care is a phone call. A phone call to the Emergency Room physician is just the beginning of my involvement with a patient in a critical condition, it is not the end. My responsibility toward my patients is much more than just one phone call. Dr. Fine's affirmation of a phone call is better than nothing, but it surely does not meet the continuity of care definition described earlier in this paragraph or the continuity of care standard that all patients, physicians included, would desire and expect of their personal physician. As said in other places in this report, I have never received a phone call in twenty-two years from a woman's abortion physician when dealing with her complication from the abortion. Without the standards of accessibility and availability that come with hospital staff privileges, the loss of continuity of care is never addressed and patient abandonment is left unchecked.

39. Plaintiffs argue that there already are emergency protocols in place for good continuity of care for women with post-abortion complications without the need to establish this requirement of admitting privileges. I disagree with this assumption. In the instance when a patient with a post-abortion complication arrives at the hospital for treatment, when not

being transported by ambulance directly from the abortion facility, it is unlikely that her medical records are available to the emergency room physician. After-hours communications and long-distance providers make conveyance of this information even less likely, much less promptly. What should happen and what does happen are very often two different worlds. This Act is consistent with the foundational principles of continuity of care, communication and doctor-patient trust that are inherent in any good treatment plan, including abortion procedures. The Act improves the standard of care for women who experience complications of an abortion procedure by enhancing continuity of care through physician availability.

40. Improved continuity of care because of physician availability improves communication between patient and physician. Poor and inconsistent communication is associated with medical errors and less than satisfactory outcomes. Evidence clearly links clinician-patient communication to patient satisfaction, adherence, and better health outcomes.[16] In the absence of communication and information flow, miscommunication occurs. Lack of communication can create situations where medical errors are more

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[16] Ong, L., de Haes, A. & Lammes, F. "Doctor-patient communication: A review of the literature. Social Science & Medicine, 1995, 40:903-918; available at: http://tusk.tufts.edu/auth/pdf/529179.pdf; Stewart, M., Brown, J.B., Boon, H., et al. "Evidence on patient-doctor communication." *Cancer Prevention & Control*, 1999; 3:25.

likely to occur which have the potential to cause severe injury or unexpected patient death. Medical errors, especially those caused by a failure to communicate, are a pervasive problem and an increasing concern today in healthcare organizations. According to The Joint Commission (TJC), if medical errors appeared on the National Center for Health Statistic's list of the top 10 causes of death in the United States, they would rank number 5, ahead of accidents, diabetes, and Alzheimer's disease, as well as AIDS, breast cancer, and gunshot wounds. More specifically, the TJC cites communication failures as the leading root cause for medication errors, delays in treatment, and wrong-site surgeries, as well as the second most frequently cited root cause for operative and postoperative events and fatal falls.[17] This Act helps ensure the availability of the physician who performs the abortion to be involved in the care of his/her patient in a medical emergency, not solely an ER physician or an Ob-Gyn physician unknown to the patient.

41. In 2000, the Institute of Medicine released "To Err Is Human."[18] The premise of this report is that "the problem in medical errors is not bad people

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[17] *O'Daniel*, M. & Rosenstein, A.H., "Professional communication and team collaboration," Ch. 33, in Hughes, R.G. (Ed.) *Patient Safety and Quality*. Rockville, MD: Agency for Healthcare Research and Quality, 2008.

[18] National Research Council – Institute of Medicine. *To Err Is Human: Building a Safer Health System*. Washington, D.C.: The National Academies Press, 2000. Available at: http://www.nap.edu/catalog.php?record_id-9729.

in health care – it is that good people are working in bad systems that need to be made safer. Poor communication, unclear lines of authority of physicians, nurses, and other care providers all contribute to medical errors." With the implementation of the Act, Texas is improving an inadequate system which essentially allows abortion providers to abandon their patients when critically ill after a procedure they performed, as well as continue a system that accepts poor communication as the norm. In effect, by not requiring admitting privileges for an abortion provider, Texas is essentially affirming that the physician who performs an abortion procedure is not responsible for ensuring that his or her patients receive adequate follow-up care when there are critical complications. This constitutes patient abandonment and very poor, substandard and fragmented medical care. Abandonment in any other circumstance is considered negligent and cause for malpractice.

E. Advantages of Local Hospital Admitting Privileges Provision: Improving Physician to Physician Communication

42. Hospital staff privileges carry with it standards for physician availability as well as standards for physician-to-physician communication inherent in physician consultation and patient transfer. According to Moorman: "Analysis of sentinel events reported to the JCAHO [now TJC] over the last decade reveals

failure of communication as the most frequent problem, cited in most of the events."[19] The Institute for Healthcare Communication asserts very clearly that good communication is critical to patient safety: "An estimated one-third of adverse events are attributed to human error and system errors. Research conducted during the 10 year period of 1995-2005 has demonstrated that ineffective team communication is the root cause for nearly 66 percent of all medical errors during that period. This means that when health care team members do not communicate effectively, patient care often suffers."[20] Hospital admitting privileges will help improve the communication between physicians in the case of post-abortion complications and help reduce poor outcomes attributable to communication errors.

43. When an abortion provider is absent in the management of his/her patient's serious complications and simply relies upon the ER physician to manage the patient's crisis, this is substandard care and is the opposite of effective communication and quality patient care. According to Cohn, good physician consultation is critical: "Effective communication is the foundation underlying the art of medical consultation; the manner in which the question or information

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[19] Moorman, D.W. "Communication, teams and medical mistakes." *Annals of Surgery*, 2007, 245, 173-175.

[20] Institute for Healthcare Communication. Impact of Communication in Healthcare. 2011. Available at: http://healthcarecomm.org/about-us/impact-of-communication-in-healthcare/.

is phrased can influence the consultant's response. The routine' consult request, for example, will generate a different response than the request for specific advice on the management of preoperative congestive heart failure Given the high frequency of misunderstanding between consultants and referring physicians, direct communication is important and likely will prevent misinterpretation."[21] Hospital admitting privileges help maintain a higher standard of accountability in the consultation process that improves communication between physicians and consultants and thus improves patient outcomes.

44. Physician to physician communication is very important. Poor conveyance of patient medical information about patients treated in different medical facilities handicaps patient care and increases the risk of adverse outcomes. According to Bourgeois and Olson:

> "Healthcare providers require timely access to patients' health information to deliver effective and safe medical treatment. However, they frequently do not have access to complete medical information, particularly for patients who have been treated at other health care facilities. Therefore, providers often rely on fragmented and incomplete medical information to make complex management

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[21] Cohn, S.L. & Macpherson, D.S. "Overview of the principles of medical consultation and perioperative medicine. *UpToDate*. June 28, 2013.

> decisions. Treating patients without complete information poses an important challenge to patient safety, increasing the likelihood of medical errors, adverse events, duplication of laboratory tests and procedures, and increased health care costs."[22]

Hospital admitting privileges create better connectedness between outpatient offices and hospitals. This connectedness helps build better information sharing (such as compatible electronic medical record systems) and in turn improves the transfer of medical information and its completeness.

45. "Communication" is mentioned only once in the reports of Drs. Fine (at ¶ 29) and Dr. Raymond (at ¶ 34), with the latter quoting the National Abortion Federation: "it encourages member clinics to 'consider developing a transfer agreement with a hospital outlining the means of communication and transport and the protocol for emergent transfer of care.'" While communication is a critical component of healthcare, the lack of it remains a major contributing factor in medical errors. According to The Joint Commission, Hospital Emergency Departments are the source of just over one-half of all reported sentinel event cases of patient death or permanent injury due to delays in treatment with breakdown in communication being

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[22] Bourgeois, F.C., Olson, K.L. & Mandl, K.D. "Patients treated at multiple acute health care facilities: Quantifying information fragmentation." *JAMA Internal Medicine*, 2010, 170: 1989-1995.

cited in 84% of cases, most often with or between physicians (67 percent).[23] These delays and lack of communication are likely to only be exacerbated by physician unavailability, particularly so when a provider is not local and flies in to perform abortions and then flies out afterwards.

46. In his Expert Report at ¶ 29, Dr. Fine minimizes continuity of care and indicates a simple telephone call is sufficient. As stated earlier, continuity of care is much more than a simple phone call. When my patients require hospitalization and the care of a specialist, this does not mean I am not involved. I am very much involved with the ongoing daily care as well as communicating consistently with the consultant and discussing treatment options. My involvement is very necessary for timely implementation of treatment as well as communicating the specific areas of my concern. Likewise, an abortion provider has an equivalent responsibility in the management of his/her patients' complications. Time delays and miscommunication work against continuity of care. The overall management and responsibility of the patient rests squarely on the shoulders of the abortion provider. To support or continue a system where this is not the case only promotes a greater likelihood of fragmented and poor care.

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[23] The Joint Commission. "Delays in Treatment." *Sentinel Event Alert*, June 17, 2002. Available at:

47 When women came to the ER with complications related to an abortion, never once did I receive a phone call initiated by the provider conveying information about the abortion, the young woman's condition or potential complications. I have also inquired of my ER physician colleagues as to how many times they were ever called by the physician who performed the abortion when they are taking care of an abortion-related complication. With over 60 years of combined service in the ER, the answer was unequivocal: "not once."

48. In the ambulatory care center that I utilize for my referrals, admitting privileges to the local hospitals nearby is a mandatory requirement for job employment for the physicians. Patient abandonment because of physician unavailability is not considered an acceptable standard of care. Physicians who do procedures need to be available if complications arise to help orchestrate the patient care and/or the consultative process that would be most beneficial for the patient and their family. Even the gastroenterologists, who I use in my referrals, who do routine outpatient colonoscopies require their physician staff to have hospital privileges in case a complication from that procedure should arise. Again, physician availability is a major component in the medical realm of communication, doctor-patient trust and continuity of care in the management of complications.

49. Physician-to-physician communication is enhanced by staff privileges. There is a different level of communication between physicians who are on staff

together and thus build relationship compared to the communication between physicians who do not know each other and are in different geographic locations. Often hospital staffs are so big that one physician cannot know every other consultant physician. Hospital privileging is beneficial in this circumstance as well. Just knowing that each physician on staff has had to pass through the same rigorous hospital credentialing process and is accountable to the same standards helps build trust and communication within the staff. When not on staff together, there will not be the same level of communication and relationship between the physicians such that transfer of care is more likely to be encumbered by time delays, poor communication and inaccurate details.[24] Optimal care implies effective communication within any physician team taking care of the patient. There is not a patient in our nation that wants physicians to be non-communicative with their other physicians about their care, especially when dealing with life-threatening issues.

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[24] The Emergency Department is a prime environment for miscommunication or insufficient communication. See generally: Kessler CS, et al. "A prospective, randomized, controlled study demonstrating a novel, effective model of transfer of care between physicians: The 5 C's of Consultation." *Academic Emergency Medicine*, 2012, 19:969-974; Talbot R & Bleetman A. "Retention of information by emergency department staff at ambulance handover: Do standard approaches work?" *Emergency Medicine Journal*, 2007, 24:539:542.

F. Advantages of Local Hospital Admitting Privileges' Provision: Reduction of Time Delays

50. Another major benefit of requiring abortion providers to have local hospital admitting privileges is that this minimizes time delays in the treatment of critical conditions. Every patient desires and hopes to receive care from a physician that they know and trust. This explains why a patient with a post-abortion complication will delay care as long as possible rather than deal with a new physician with whom they have not established a relationship of trust. This time delay alone can have permanent implications on patient outcomes.

51. A time delay that can be substantial is the time spent in the Emergency Room waiting area. If the Emergency Room doctor has received no communication from the abortion physician about a possible post-abortion patient with a complication, that patient might have to wait her turn with the other patients in the waiting area. If the ER doctor and staff know to look for her, then intervention can be made much timelier and not lose 1-3 hours waiting. A time delay of one hour can mean the difference between life and death in severe cases of infection or internal bleeding.

52. Without the direct benefit of ever being able to speak with the abortion provider whose patient has experienced severe complications and presents at the ER, I have always had to begin the evaluation

without the benefit of this medical information, come to my own conclusions, and initiate what I thought was appropriate treatment. This definitely created some time delays that were not in the patient's best interest. I have called many abortion clinic physicians but never once did the provider come to the Emergency Room to assume care. I have always had to call a staff Ob-Gyn. This then creates another time-delay since the staff physician is taking care of his/her own patients but now must change his/her schedule to assume the care of someone else's patient. These delays can have life-threatening implications when dealing with hemorrhage or infection.[25]

53. In Dr. Fine's Expert Report at ¶ 29, he states: "in the rare case in which the patient needs to be transferred by ambulance to a hospital, the quality of care that the patient receives is not affected by whether the abortion provider has admitting privileges at the hospital. An emergency room physician will decide if it is necessary to involve an ob/gyn in

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[25] A tragic example is that of 24 year old Tonya Reaves. Planned Parenthood of Illinois settled a wrongful death suit brought against it by the family of Ms. Reaves. Ms. Reaves had an abortion at 16 weeks at PPI's Chicago Loop office, began hemorrhaging, yet METs were not called for over 5 hours. At the hospital she subsequently had another dilation and evacuation procedure and died from uncontrollable hemorrhaging 12 hours after her abortion. See: *CBS News*. Documents shed light on woman's death after abortion. July 24, 2012. Available at: http://chicago.cbslocal.com/2012/07/24/documents-shed-light-on-womans-death-after-abortion/; and http://chicago.cbslocal.com/2012/08/27/mother-of-woman-who-died-after-abortion-sues-planned-parenthood-hospital/.

the patient's care, and if so, he or she will contact the ob/gyn on call at that hospital, who can admit the patient if necessary. All ob/gyns, regardless of whether they perform abortions, are qualified to manage the care of a patient experiencing a complication from an abortion, and to refer the patient, where necessary, to the appropriate subspecialist." Dr. Fine's statement makes several erroneous assumptions: (a) that this process is simple and inevitable; (b) that doctors are available; and (c) that communication is seamless. This has not been my experience in medicine. In addition, Dr. Fine's opinion above does not at all acknowledge the 'time factor' inherent in this scenario. ER physicians and Ob-Gyn staff, hopefully as all physicians, are readily available for emergencies but it is presumptuous for one group of physicians, i.e., abortion providers, to expect that others are available for their patients' complications so they can be relieved of their responsibilities.

G. Serious, Severe and Life-threatening Complications of Abortion

54. Post-abortion complications can be serious and life-threatening. The two most common of the serious and life threatening complications of an abortion are infection and profuse post-abortion bleeding. Time delays, as little as one hour, can mean the difference between life and death.

55. Post-abortion infection can be the result of bacterial spread from retained fetal parts, uterine

perforation, colon perforation or poor uterine contraction and persistent bleeding post-abortion. As in many areas of emergency care, time has been proven to be of critical importance. The amounts of bacteria that invade the blood stream or contaminate normally sterile compartments make the time until initiation of antibiotic treatment the top priority. Uterine perforation or colon perforation can cause an infection which grows and spreads very quickly because so many bacteria are introduced into the abdominal cavity and blood stream. Sepsis is a clinical syndrome that complicates severe infection. It is theorized that the infection sets in motion a massive inflammatory response, "an uncontrolled release of pro-inflammatory mediators that initiate a chain of events that lead to widespread tissue injury. This response can lead to multiple organ dysfunction syndrome (MODS) which is the cause of the high mortality associated with sepsis."[26] The mortality rate associated with sepsis ranges from 20-50%.[27] The medical literature affirms the importance of early treatment: "early institution of adequate antibiotic therapy was associated with a 50% reduction in the mortality rate."[28] The medical literature emphasizes the necessity of early intervention in sepsis: "poor outcomes are associated with

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[26] Neviere, R. "Sepsis and the systemic inflammatory response syndrome: Definitions, epidemiology, and prognosis": *UpToDate*, 11/14/2013, p. 1.

[27] Neviere, R. ibid, p. 4.

[28] Neviere, R., ibid. p. 5.

delays in initiating antimicrobial therapy, even short delays (e.g., one hour)."[29] A retrospective analysis of 2,731 patients with septic shock demonstrates that the time to initiation of appropriate antimicrobial therapy was the strongest predictor of mortality.[30] With this clear emphasis on early treatment to reduce the morbidity and mortality associated with sepsis and severe infection, it is in the woman's best interest to reduce delays in treatment so that medical intervention is not postponed. If the abortion provider has local hospital admitting privileges, this will reduce potential delays in the initiation of treatment for infection or hemorrhage. As affirmed by the medical literature, as well as my own clinical experience, even short time delays can have life-threatening implications.

56. Post-abortion bleeding, another complication of abortion, can be life-threatening and is hard to recognize in its early stage. Prolonged bleeding can result in the under-perfusion of vital organs, including brain, heart and kidneys, which can have implications up to, and including death. It is very difficult for a woman to be able to distinguish between "normal and acceptable" post-abortion bleeding and dangerous bleeding. Symptoms of early volume loss are minimal because people have such good compensatory circulatory mechanisms to shunt blood from non-essential

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[29] Schmidt, G. "Management of severe sepsis and septic shock in adults." *UpToDate*, 2014. p. 7.

[30] Schmidt, G., ibid, p. 8.

organs to essential core organs. If bleeding is heavy, a patient can deteriorate in over one hour's time from a fragile but recoverable situation to one of grave or irreversible prognosis. Not all post-abortion bleeding is visible (intra-abdominal bleeding from a uterine vein tear or a colon puncture involving an artery or vein), but even in the cases in which it is visible (vaginal bleeding from poor uterine contractions, retained fetal parts or infection), a woman cannot accurately recognize what a dangerous amount of bleeding is in order to respond appropriately. Even experienced emergency medical technicians and surgeons often have difficulty accurately predicting the amount of blood loss when viewing the scene or situation. The availability of her operating physician is of utmost importance in the management of her complication(s). The actual degree of blood loss can only be determined by the patient's symptoms, vital signs, organ function and lab values. If a woman knows her physician does not practice at a local hospital, then she is faced at that moment with having to change physicians and possibly have to wait in a crowded Emergency Room to see a doctor she has never met. Both are a hurdle that most patients try to avoid. If the abortion provider met her at the ER, then a quicker evaluation and lab monitoring is possible and therefore an earlier intervention takes place. If she knows her physician does not practice at the hospital, she will likely put off going to the hospital as long as possible.

57 From both my medical experience and my continuing review of the medical literature, early intervention is paramount in order to reduce morbidity and mortality from massive blood loss.[31] Initiating treatment as fast as possible is of top priority. A drop in blood pressure and increased heart rate are the most common signs of hypo-perfusion but critical hypo-perfusion can also occur in the absence of hypotension as the compensatory circulatory mechanisms try to prevent collapse. The medical literature strongly emphasizes the need for early intervention: "Initial management of the patient with hemorrhagic shock is focused on restoring intravascular volume, maintaining adequate oxygen delivery, and limiting ongoing blood loss."[32] Additionally, rapid volume repletion is indicated in patients with severe hypovolemia or hypovolemic shock. "Delayed therapy can lead to ischemic injury and eventually to irreversible shock and multi-organ system failure."[33] Early correction of this volume deficit is essential in hypovolemic shock to prevent the decline in tissue perfusion from becoming irreversible.[34]

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[31] Schmidt, G., ibid, p. 10.

[32] Colwell, C. "Initial Evaluation and Management of Shock in Adult Trauma." *UptoDate*, 1/29/2014, pp. 1-2.

[33] Mandel & Pavlesky. "Treatment of Sever Hypovolemia or Hypovolemic Shock in Adults." *UpToDate*, 2013, p. 1.

[34] Mandel, J., ibid. p. 1.

H. Ensuring High Standards for Patient Safety

58. Recent media attention has focused on examples of egregious and substandard abortion care by both abortion providers and clinics. Of course these cases do not suggest that all abortion providers are deficient and/or dangerous. They do, however, identify problems that improved state surveillance and regulation would help remedy. Some abortion providers and clinics may do quality control on their own. However, others have not been held to the quality standards of hospitals and their medical staffs. One way to eliminate this identified deficiency in oversight is to mandate hospital credentialing and privileging for abortion practitioners.

59. Besides the abortion providers previously mentioned, there are others who have been investigated, shut down, and sometimes convicted for providing substandard care to their patients. The most comprehensive and detailed listing of these providers I have found is a 2013 report compiled by the Susan B. Anthony List, a pro-life organization.[35] I have expanded that list and it is attached as **Exhibit B**, entitled: "Examples of Substandard Abortion Practices." I have also searched pro-choice websites and was only able to find two websites that mentioned

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[35] Susan B. Anthony List. *Fact Sheet: Abortion Industry Negligence Nationwide*. Available at: http://www.sba-list.org/sites/default/files/content/shared/09.11.13_updated_fact_sheet.pdf.

"substandard providers," namely, the National Abortion Federation and RH Reality Check. Both identified only two providers: Dr. Hermit Gosnell and Dr. Steven Brigham.[36]

60. One pro-choice website, Abortion Care Network (abortioncarenetwork.org) provides a cautionary editorial about substandard abortion care: "So each

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[36] Patient safety can be all too easily compromised by physician financial conflict of interests. Dr. Steven Brigham's American Women's Services multi-state abortion businesses are illustrative of the need for hospital staff credentialing and privileging. Under "Employment" on their website, the job specification for clinic physician identifies: "Lucrative opportunity for Physician with progressive pro-choice women's centers. No on-call responsibility. Any specialty will be considered. All MDs/ODs welcome (including GPs, FMGs and residents). No experience necessary, we will train. Flexible Schedules to accommodate your needs. Great Opportunity for MDs in private practice who wish to supplement their incomes, or for doctors seeking a Full-time lucrative opportunity Board eligibility not required." Only two requirements are necessary: "Must have an active license to practice medicine. Must be pro-choice and respectful of women." *See*: http://www.americanwomenservices.com/employment/display_position.php?pos_id=2. For more information regarding Dr. Brigham and his financial ties with both American Women's Services and Associates in Ob/Gyn Care, whose four Maryland clinics were recently suspended by the State for serious and immediate danger to patients, see: http://mobile.nytimes.com/2013/07/11/us/marylands-path-to-an-accord-in-abortion-fight.html?from=health. See also: Coutts, S. "For Decades, Authorities Let Rogue Abortion Provider Harm Women, Despite Pleas From Legitimate Doctors." *RH Reality Check*, July 11, 2013. Available at: http://rhrealitycheck.org/article/2013/07/11/for-decades-authorities-let-rogue-abortion-provider-harm-women-despite-pleas-from-legitimate-doctors/

woman who is thinking about abortion is on her own. And they [patients who obtain abortions] may not report substandard care to health authorities because they don't want to jeopardize their own confidentiality. Or they may not even realize that they deserve better." *See*: http://www.abortioncarenetwork.org/blog-1/secrecy-and-stigma-the-roots-of-substandard-abortion-care. Indeed women with unwanted pregnancies deserve much better, and in my opinion, they deserve to have providers who are trustworthy caregivers and who are competent, peer-reviewed and evaluated by hospital medical staff. This is reasonable and protective of patient safety. Furthermore, the Abortion Care Network cautions abortion consumers: "The quality of care can vary widely among all medical facilities and since many women do not talk about their abortion experiences, it is often difficult to know what to look for when choosing a clinic." *See*: http://www.abortioncarenetwork.org/considering-abortion/choosing-a-quality-clinic.

I. Other Incongruities

61. Plaintiffs' expert Dr. Fine argues in his Expert Report at ¶ 30 that requiring an abortion provider to have hospital privileges within 30 miles of the abortion clinic would have no bearing as to where an EMT would transport a patient with abortion complications. From my twenty-two years in the second busiest emergency room in the state of Virginia, it was always the case that the EMT's would do their best to accommodate the desires of the patients and

medical doctors. If the patient was in extreme distress, it is true that the closest ER was the logical choice but otherwise, they would transfer the patient where continuity of care was best for that patient. The patient's medical doctors and medical records were the deciding factor as to where they would transport stable patients.

62. In my opinion, Plaintiffs' arguments in opposition to the admitting privilege requirement are specious. In Texas, a number of abortion providers do indeed hold admitting privileges at local hospitals, including Plaintiffs' expert, Dr. Fine. It is illogical and unreasonable to argue against the value of hospital privileging in abortion services on the one hand, while acknowledging that many Texas abortion facilities already comply with this provision of the Act. In addition, there are six Texas abortion facilities licensed as ambulatory surgery centers.[37] If these providers and facilities can meet the requirements of the law, it is reasonable to assume others can as well. With the closures of the abortion clinics in El Paso and McAllen, one or both could reopen with new physicians qualified for local hospital admitting privileges and the conversion to an ambulatory surgery center. Then too, new abortion facilities may open in the future in these areas and/or others. If not, as is

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[37] Aaronson, B. "Interactive: The impact of HB 2 on Texas Abortion Facilities." Texas Tribune, March 19, 2014. Available at: http://www.texastribune.org/2014/03/19/impact-hb2-regulations-abortion-facilities-over-time/.

true in other areas of medical specialization, Texas patients will travel to those facilities nearest them to address their healthcare needs despite inconvenience and increased costs. If a reduction in the number of abortion facilities results in more travel but safer procedures for patients, it is a reasonable and prudent trade-off of convenience for healthcare quality and risk reduction. Plaintiffs argue that many patients cannot afford to pay for longer distance travel, but I believe that the poverty situation of these patients does not warrant providing them with substandard care. Abortion patients in poverty deserve the same standard of healthcare as those who are wealthier in our society.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

Whole Woman's Health; Austin Women's Health Center; Killeen Women's Center; Nova Health Systems d/b/a Reproductive Services and Sherwood C. Lynn, Jr., M.D.; Pamela J. Richter, D.O.; and Lendol L. Davis M.D., on behalf of themselves and their patients, Plaintiffs, v. **David Lakey, M.D. and Mari Robinson,** in their official capacities, Defendants.	Civil Action No. 1:14-cv-284-LY

DIRECT TESTIMONY OF TODD GIBERSON

(Submitted Aug. 6, 2014)

I am a Systems Analyst employed by the Office of the Attorney General of Texas, serving as Deputy Chief of the Legal Technical Support Division. In that capacity, I routinely work with geographic information systems (GIS), census data, and custom programming to analyze geographic data In the course of my employment at the Attorney General's Office and in my previous training, I have had extensive experience

employing mapping technology to generate demographic and geographic data regarding the Texas population. I have provided numerous analyses in affidavits and on occasion as a testifying witness on matters related to the geography of the state of Texas and specialty programming to analyze data As part of my employment, I have a great deal of experience analyzing and creating redistricting maps for Texas legislative districts. I have previously testified as a mapping expert in redistricting litigation. Through this work, I have gained extensive knowledge of Texas geography.

I understand Plaintiffs oppose select provisions of Texas House Bill 2, referred to in this report as "the Act." Those provisions are: that "a physician performing or inducing an abortion must, on the date the abortion is performed or induced, have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced " (the "admitting privileges requirement") and that effective September 1, 2014, the Act requires licensed abortion clinics in Texas to meet the equivalent minimum standards adopted under [Texas Health & Safety Code] Section 243.010 for ambulatory surgical centers" (the "ASC requirement"). Act, § 4 (codified at Tex. Health & Safety Code Ann. § 245.010(a)); 25 Tex. Admin. Code § 139.40.

I have reviewed the expert report of Dr. Daniel Grossman. I have no personal or expert knowledge of the abortion industry. As explained below, I performed

demographic and mapping calculations at the request of attorneys for the State based solely on information provided to me by those attorneys.

I understand that the Plaintiffs in this case will attempt to prove that the Act substantially obstructs access to elective abortion for a significant number of Texas women. In his expert report (at ¶¶ 10-12 and Figure 2), Dr. Grossman purports to calculate the number of women ages 15 through 44 (15-44) living within 50, 100, and 200 miles of an abortion provider at various points in time. From these calculations, Dr. Grossman concludes that recent and anticipated abortion clinic closures "have had a significant negative impact on women's ability to obtain abortion services in Texas." Grossman Report ¶ 11.

Dr. Grossman's calculations are based on a county-by-county analysis. *Id.* ¶ 37 This analysis may be imprecise for several reasons. First, the calculation of travel time from one county to another is an imprecise measure. For example, Dr. Grossman does not explain how he determines whether a county is within a certain distance of a facility other than to refer to the Google Distance Matrix. Is this calculation based on the distance between the counties' nearest points, or based on county centerpoint to county centerpoint, or based on some other measure? How might the actual location of the facility affect the distance calculation? Further, Dr. Grossman's population figures are based on estimates drawn from county-wide population figures. He either includes the population of an entire county or excludes the

population of an entire county from the 100-mile travel distance (or the 50-mile or 200-mile distances), but, as stated above, he does not explain on what basis the county was excluded or included. As a result, his calculations may not accurately reflect the number of Texas women age 15-44 who live within a given distance of an abortion provider.

To produce more reliable figures, I used GIS software and custom computer programming, together with a geographic dataset of major highways throughout the State, to closely approximate areas within a prescribed distance from the actual location of the provider facilities.

I understand that the Fifth Circuit Court of Appeals has determined that a 150-mile distance between a woman's home and the nearest abortion provider is not a substantial obstacle to obtaining an abortion. I understand that the Fifth Circuit Court of Appeals has also determined that travel time of three hours from a woman's place of residence to the nearest abortion provider is not a substantial obstacle to obtaining an abortion. This information was provided to me by attorneys for the State, and I express no opinion on legal matters. At the request of attorneys for the State, I sought to (A) closely estimate the number of women living within 150 miles of various abortion provider addresses provided to me by attorneys in my office and (B) additionally, the number of women living in urban areas beyond 150 miles but within a three hour drive of various abortion provider

addresses provided to me by attorneys in my office. Those addresses are:

1. Texas Ambulatory Surgical Center
   2505 N. Shepherd Dr
   Houston, TX 77008

2. Planned Parenthood South Austin
   201 E. Ben White Blvd
   Austin, TX 78704

3. Southwestern Women's Surgery Center
   8616 Greenville Ave
   Dallas, TX 75243

4. Planned Parenthood Center for Choice
   4600 Gulf Freeway
   Houston, TX 77023

5. Whole Women's Health San Antonio
   4025 East Southcross Blvd
   San Antonio, TX 78222

6. Planned Parenthood of Greater Texas
   6464 John Ryan Dr
   Fort Worth, TX 76132

7 Hilltop Women's Reproductive Clinic
   5290 McNutt Rd
   Santa Teresa, NM 88008

8. Reproductive Services of El Paso
   730 E. Yandell
   El Paso, TX 79902

9. Whole Woman's Health
   802 S Main St
   McAllen, TX 78501

10. Planned Parenthood Women's Health Center
3302 67th St
Lubbock, TX 79413

A. Women Aged 15-44 Residing Within 150 miles of Provider Facilities

To estimate the number of Texas women age 15-44 who live within 150 miles of the relevant clinic addresses, I first generated a geographic network of nodes interconnected by major roads in the state. The physical location of each provider address was also added as a node in the network. Using these facility addresses as starting nodes, shortest road distances were calculated to all other nodes in the geographic dataset using Dijkstra's shortest path algorithm. With these distances calculated I was then able to create polygons that enclosed all nodes within the 150 mile distance from each facility. While a precise distance between nodes is known, there was some estimation on my part in determining where the 150-mile line would be drawn between nodes. After generating a first set of numbers, I decided to refine the polygons by breaking line segments in the road network with additional nodes in critical areas, minimizing the amount of estimating I havd previously done.. In the refined lines I believe I was able to reach a level of precision in which the possible error for any given 150-mile distance line is no more than a few tenths of a mile along a road. Further refinement would not have had any material impact on the final number of people determined to live within the 150

mile distance. This is particularly true because the 150-mile lines are almost all in rural areas, where slight adjustments to the line would have little or no impact on the numbers.

Overlapping polygons for the six ASC providers in Austin, Dallas, Fort Worth, Houston (2), and San Antonio were combined into one area (addresses 1 through 6). Where there is overlap in the other 150-mile areas, precedence is given to the areas calculated for open facilities. Notably, the polygon for the El Paso facility only adds a thin sliver of additional territory to the east of the boundary calculated for the New Mexico facility. See Map 1 titled "150 mile Road Distance from Provider Facilities" in Section III below. Using these polygons together with a geographic overlay procedure, each census block in the state was assigned to one of these 150-mile areas (or left unassigned) based on where the block predominantly fell.

I estimated the total female population aged 15-44 for each area by summing the population of females of that age for all census blocks in the various areas based on data published by the Census Bureau. I used 2010 Census data, even though the Census Bureau has released more recent American Community Survey (ACS) data as of 2012. The ACS data is only released in as fine a geographic unit as its "block group" level, while the 2010 Census data is available at the finer "block level." Further, the ACS data is generated using statistical sampling methods rather than being an enumeration, like the Census. Use of

the more recent Community Survey data would not have materially affected the results because the focus of my results are percentages rather than raw numbers.

The analysis described above yielded the following estimates (see Table titled "150-mile Road Distance from Provider Facilities" in Section III below):

1. With respect to the addresses numbered 1 through 6 above, 83.3% of Texas women ages 15-44 live within 150 miles of at least one of these addresses.

2. With respect to the addresses numbered 1 through 7 above, 86.5% of Texas women ages 15-44 live within 150 miles of at least one of these addresses.

3. 6.2% of Texas women ages 15-44 live within 150 miles of address 9 (McAllen) but NOT within 150 miles of any of addresses 1 through 7.

4. The inclusion of address 8 has essentially no impact on the numbers because the area at issue is small and sparsely populated. My estimates indicated that 6 women ages 15-44 live within 150 miles of address 8 but NOT within 150 miles of addresses 1 through 7

5. 4.3% of Texas women ages 15-44 live within 150 miles of address 10 (Lubbock) but NOT within 150 miles of any of addresses 1 through 7

6. Only 2.9% of Texas women do not live within 150 miles of any of the addresses 1 through 10.

I have been told that it is undisputed that the abortion provider formerly located at address 10 closed for reasons unrelated to the Act. Assuming this is true, the figures in ¶10 and ¶ 12 of Dr. Grossman's report are misleading to the extent Dr. Grossman intends to attribute to the Act the *entirety* of the increase in the number of women living outside his chosen distances. Because of the geographic isolation of the Lubbock address and its proximity to Amarillo and the Midland/Odessa area, it is estimated that 228,484 women ages 15-44 now reside more than 150 miles from an abortion clinic due solely to the closure of the Lubbock abortion provider. Dr. Grossman's report makes no attempt to account for the fact that these women reside more than 150 miles from an abortion clinic for reasons that are not attributable to the Act. As a result, Dr. Grossman's assumptions inflate the number of women he suggests affected by the Act.

Dr. Grossman's calculations reflect only abortion providers located in Texas. By including the Santa Teresa, New Mexico abortion provider (which is three-fourths of a mile from the Texas-New Mexico border and readily accessible to El Paso via Country Club Dr.), the distance that women in West Texas must travel to reach an abortion provider can more accurately be determined. As with his inclusion of the Lubbock clinic in his baseline numbers, Dr. Grossman's exclusion of the Santa Teresa clinic inflates his estimates of the number of Texas women who

live more than a given distance from an abortion provider.

I note that Dr. Grossman's report assumes that a net of 13 abortion providers will close between now and 9/1/2014. See his Table 1. I was not asked to perform calculations to determine the number of additional women age 15-44 that would be brought within a 150-mile distance of an abortion provider with these clinics being open. The number would have been very small. All of these clinics identified by Dr. Grossman are in metropolitan areas already containing an abortion provider numbered 1 through 7 above. Adding additional clinics within these metropolitan areas would not have had a significant effect on the number of women residing within 150 miles of an abortion clinic.

In conclusion, based on the above-described calculations and on information reported to me by attorneys for the State, I estimate that 93.8% of Texas women ages 15-44 either live within 150 miles of at least one of the abortion providers numbered 1 through 7 or live in an area that is not within 150 miles of an abortion provider due to reasons not alleged to be the Act. If the Santa Teresa, NM clinic is excluded from the analysis, I estimate that 90.6% of Texas women ages 15-44 live within 150 miles of at least one of the abortion providers numbered 1 through 6 or live in an area that is not within 150 miles of an abortion provider due to reasons not alleged to be related to the Act.

B. Women Aged 15-44 Residing Within 3-Hour Drive of Provider Facilities

As noted above, I understand that that the Fifth Circuit Court of Appeals has determined that travel time of three hours from a woman's place of residence to the nearest abortion provider is not a substantial obstacle to obtaining an abortion. The 150-mile distance described above corresponds to a conservative estimate of a three hour drive assuming an average driving speed of 50 miles per hour. However, several urban areas that are outside of the 150-mile distance from an abortion clinic are clearly within a three hour drive of an abortion clinic via major highways or interstates where average speeds higher than 50 miles per hour can be maintained. Therefore, I have produced a second set of estimates of women aged 15-44 which takes into account a three hour drive time from selected urban areas to an abortion clinic. I chose three urban areas for evaluation: Laredo (with its proximity to the San Antonio facility), Abilene (to the Fort Worth facility), and Texarkana (to the Dallas facility). All of these areas connect to the provider city by way of an interstate highway.

Using Google Maps, I was able to determine that all parts of the evaluated cities were within a three hour drive of a facility. To represent this finding. I generated 15 mile zones (30 minutes at an assumed 30 mph) from points 2.5 hours from the nearest abortion facility. Thus all points within these zones would be within three hours (2.5 hours plus 30 minutes) of the nearest abortion clinic. Areas thus

added to the analysis were calculated separately from the other areas previously summarized. (See Map 2 which includes "estimated 3 hour drive time extensions" in Section III below.)

The analysis described above yielded the following estimates (see Table which includes "3-hour Drive from Provider Facilities" in Section III below):

1. With respect to the addresses numbered 1 through 6 above, 84.9% of Texas women ages 15-44 live within a 3-hour drive of at least one of these addresses.

2. With respect to the addresses numbered 1 through 7 above, 88.2% of Texas women ages 15-44 live within a 3-hour drive of at least one of these addresses.

3. 5.4% of Texas women ages 15-44 live within a 3-hour drive of address 9 (McAllen) but NOT within a 3-hour drive of any of addresses 1 through 7.

4. The El Paso area calculations are unchanged from the previous results.

5. 4.3% of Texas women ages 15-44 live within a 3-hour drive of address 10 (Lubbock) but NOT within a 3-hour drive of any of addresses 1 through 7.

6. Only 2.1% of Texas women do not live within a 3-hour drive of any of the addresses 1 through 10.

In conclusion, based on the above-described calculations and on information reported to me by attorneys for the State, I estimate conservatively that 94.6% of Texas women ages 15-44 either live within a 3-hour drive of at least one of the abortion providers numbered 1 through 7 or live in an area that is not within a 3-hour drive of an abortion provider due 120 reasons not alleged to be related to the Act. If the Santa Teresa, NM clinic is occluded from the analysis, I estimate that 91.3% of Texas women ages 15-44 live within a 3-hour drive of at least one of the abortion provides numbered 1 through 6 or live in an area that is not within a 3-hour drive of an abortion provider due to reasons not alleged to be related to the Act.

III. Exhibits To Be Used to Summarize or Support My Opinions

150-mile Road Distance from Provider Facilities

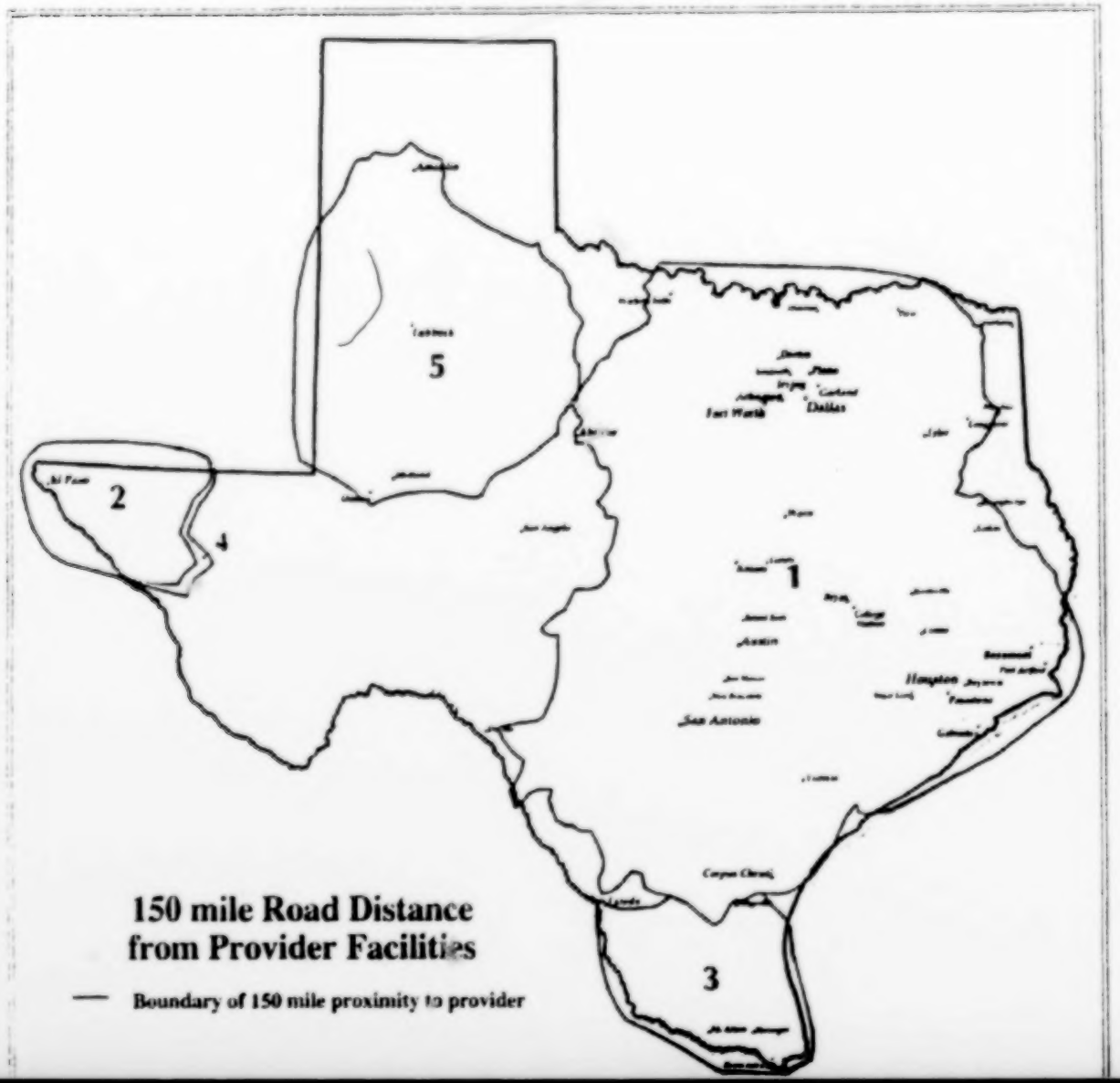
Area	Population	Females Age 15-44	Percent of Females 15-44 in State
0—Not Covered	840,217	156,466	2.9%
1—Six ASC facilities	20,837,519	4,434,274	83.3%
2—New Mexico facility	806,457	174,295	3.3%
3—McAllen facility	1,524,832	332,637	6.2%
4—El Paso facility	45	6	0.0%

5—Lubbock facility	1,136,491	228,484	4.3%
State Totals	**25,145,561**	**5,326,162**	**100.0%**

150-mile Road Distance from Provider Facilities or 3-hour Drive from Provider Facilities

Area	Population	Females Age 15-44	Percent of Females 15-44 in State
0—Not Covered	619,639	111,573	2.1%
1—Six ASC facilities	20,837,630	4,434,291	83.3%
2—New Mexico facility	806,457	174,295	3.3%
3—McAllen facility	1,326,011	288,321	5.4%
4—El Paso facility	45	6	0.0%
5—Lubbock facility	1,132,287	227,708	4.3%
6—Laredo Extension	247,674	56,379	1.1%
7—Abilene Extension	87,861	17,447	0.3%
8—Texarkana Extension	87,957	16,142	0.3%
State Totals	**25,145,561**	**5,326,162**	**100.0%**

Map 1. 150-mile Road Distance from Provider Facilities



Map 2. 150-mile Road Distance or 3-hour Drive from Provider Facilities

No. 15-274

Supreme Court, U.S.
FILED
CLERK

In The Supreme Court of the United States

WHOLE WOMAN'S HEALTH ET AL. PETITIONERS

v.

KIRK COLE, M.D., COMMISSIONER OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

JOINT APPENDIX VOLUME VI

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH, ABORTION ADVANTAGE, AUSTIN WOMAN'S HEALTH CENTER, KILLEEN WOMAN'S HEALTH CENTER, NOVA HEALTH SYSTEMS, SHERWOOD C. LYNN, JR. M.D., PAMELA J. RICHTER D.O., LENDOL L. DAVIS M.D.,	AU:14-CV-00284-LY
VS.	
DAVID LAKEY M.D., MARI ROBINSON.	AUSTIN, TEXAS AUGUST 6, 2014

* *

TRANSCRIPT OF BENCH TRIAL
BEFORE THE HONORABLE LEE YEAKEL

VOLUME 3 OF 5

* *

* * *

[4] MAYRA J. THOMPSON,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. STEPHENS:

Q. Good afternoon, Dr. Thompson?

A. Good afternoon.

Q. Could you please state your full name for the record.

[5] A. Yes. My name is Mayra Jimenez Thompson.

Q. And there's a binder to your right. I'd like you to refer to the first tab of that binder and the document titled Direct Testimony of Mayra Jimenez Thompson, M.D. Do you see that document?

A. Yes.

Q. And if you could take a moment to look through that document.

A. Yes.

Q. Dr. Thompson, are you familiar with that document?

A. Yes.

Q. And is it true and accurate statement of the direct testimony that you will be offering today?

A. Yes.

MR. STEPHENS: Your Honor, the State offers the document labeled direct testimony of Mayra Jimenez Thompson, M.D. into the record as the direct testimony of Dr. Thompson.

THE COURT: Any objection from the plaintiffs?

MS. TOTI: Your Honor, we'd like to renew our objection to the reliability of this testimony.

THE COURT: You're objecting to the reliability of the testimony?

MS. TOTI: Yes, Your Honor. We'd like to establish further foundation for that objection during the cross-examination.

[6] THE COURT: Well, you may.

MS. TOTI: Thank you, Your Honor.

THE COURT: Then I'm going to conditionally admit the direct testimony of Mayra Jimenez Thompson, M.D., and you have not waived any motion you have for me to disregard it at a later time.

MS. TOTI: Thank you, Your Honor.

MR. STEPHENS: Your Honor, the State passes the witness.

CROSS-EXAMINATION

BY MS. TOTI:

Q. Good afternoon, Dr. Thompson. Dr. Thompson, you are an obstetrician-gynecologist, correct?

A. Yes.

Q. But you haven't performed an abortion procedure in over 20 years, correct?

A. I'm sorry?

Q. You have not performed an abortion procedure in over 20 years; is that correct?

A. Approximately, yes.

Q. And that's because you have religious objections to abortion?

A. Yes.

Q. You are testifying in this case as an expert; is that right?

[7] A. Yes.

Q. What is the nature of your expertise?

A. I am an experienced practicing OB-GYN since 1980, when I started my residency program, and I am actively involved in the care of women, both medically and surgically.

Q. And you submitted an expert report in this case; is that correct?

A. Yes.

Q. And the opinions that you're offering in your direct testimony are the same as those you offered in your expert report; is that correct?

A. Yes.

Q. Now, at your deposition I believe you testified that no one other than the attorneys for the defendants gave you advice or guidance about

developing the content of your expert report; is that correct?

A. I specifically said nobody in the attorney's office.

Q. So—so someone else other than the attorneys did give you advice and guidance about the content of your expert report; is that correct?

A. I don't know what you mean by "advice."

Q. Who drafted your expert report?

A. Would you repeat that?

Q. Who drafted the expert report that you submitted in this case?

[8] A. I drafted it.

Q. In fact, didn't Vincent Rue draft your expert report?

A. No.

Q. In fact—

MR. STEPHENS: Your Honor, the State is going to object to any line of questioning involving the—regarding the involvement of Vincent Rue on the basis that Vincent Rue's communications with the witness are privileged.

THE COURT: Tell me how they are privileged.

MR. STEPHENS: Your Honor, we're objecting to the use at trial of any communications between Dr. Rue and any testifying expert of the State as privileged under Rule 26 for the reasons stated in the document number 146 filed in the case and the State's objections to Judge Austin's ruling.

The communications are privileged under Rule 26(b)(3)(A) because they reflect the work product of a consultant and an agent of the State. They're privileged under Rule 26(b)(4)(C), because they are communications between a testifying expert and an agent of the State's lawyers. In particular, any drafts of expert reports are privileged under Rule 26(b)(4)(B). And at the time of those communications, they were considered confidential by their participants and were treated that way until Judge Austin's ruling.

And for those reasons, the State asks that the Court order that those communications not be used at trial.

[9] THE COURT: Well, how do I know where they infringed on communication if she's just asking the witness oral questions?

MR. STEPHENS: Your Honor, if—we would preserve the objection to the extent that they introduce any actual documents reflecting those communications. If the nature of the questioning is whether the communications occurred, then there's no objection.

THE COURT: I'm going to allow her to develop whether the communication occurred, and then we'll deal with particular communications later.

MR. STEPHENS: Thank you, Your Honor.

Q. (BY MS. TOTI) Dr. Thompson, isn't it true that Vincent Rue took the lead in drafting your expert report in this case?

A. No.

Q. Isn't it true that you sent Dr. Rue certain materials that you wanted him to include in the expert report, and he declined to include those materials?

A. No.

MS. TOTI: Your Honor, I'd like to mark a document to help refresh the witness's recollection about this matter.

MR. STEPHENS: Your Honor, is it being offered as an exhibit or marked as an exhibit?

THE COURT: Well, it hadn't even been marked yet.

MR. STEPHENS: Well, she said "marked." I'm not sure [10] if that means introduced.

THE COURT: Well, I haven't heard her offer it as an exhibit yet.

MS. TOTI: I'd like to mark it for identification, Your Honor, and show the witness to help refresh her recollection.

THE COURT: All right. And what are you marking it?

MS. TOTI: And, Your Honor, I just also want to note that some of these documents were produced to us at about 2:30 this morning, and we were asked at that time if we could redact anything that was going do be used in Court today. I said that we would. I wasn't aware that there was going to be additional objections. I thought we had resolved this matter in front of Judge Austin and Your Honor. But if I could just take a moment to make the redactions and mark the exhibit.

THE COURT: Take the time you need.

MS. TOTI: Thank you, Your Honor.

Q. (BY MS. TOTI) Okay. Dr. Thompson, have you ever seen this document before that has been marked for identification as Plaintiffs' Exhibit 211?

A. I believe I have.

Q. And what is this document?

A. It's an E-mail.

Q. This is an E-mail from Vincent Rue to yourself dated June 29th, 2014; is that correct?

[11] A. Yes.

Q. And the E-mail says—

THE COURT: Wait a minute. Don't read from the document until it's admitted as an exhibit.

MS. TOTI: Thank you, Your Honor.

Q. (BY MS. TOTI) Does this document refresh your recollection as to whether Vincent Rue is the person who drafted your expert report?

A. I don't know what you mean by "drafting."

Q. Well, I'd like you to take a look at the second sentence in the document. Just read it to yourself, please.

A. (Complies)

Q. What did you understand this E-mail to mean when you received it?

A. That he is writing something.

Q. And what was he writing?

A. I don't know exactly.

Q. You don't know what he was writing on June 29th, 2014 at 7:03 p.m.?

A. I don't know which—what he's referring to exactly at this particular time.

Q. Okay. Well, I've got plenty of documents in this box to help refresh your recollection. Are you sure you don't remember as you're sitting here now?

A. I don't remember.

[12] Q. Okay.

THE COURT: Ms. Toti, I realize—I realize you may have gotten these documents early this morning, but it would have been helpful had you marked them and redacted them before we got to court today. I think we can make more progress if we do something other than have me observe you mark and redact new exhibits. I'd like to move through the witnesses as quickly as we can.

MS. TOTI: I understand, Your Honor. I'll try to move very quickly.

Q. (BY MS. TOTI) Dr. Thompson, I would like to show you what has been marked for identification as Plaintiffs' Exhibit 212.

MS. TOTI: Your Honor, I'm just going to avoid for now putting them up on the screen, and perhaps we can redact them later?

THE COURT: That will be fine.

MS. TOTI: Okay.

Q. (BY MS. TOTI) Dr. Thompson, have you seen this document before?

A. Yes.

Q. It's marked for identification as Plaintiffs' Exhibit 212?

A. Yes.

Q. Is this a continuation of the E-mail chain that we were just looking at?

A. Yes.

[13] Q. So this is an E-mail chain between yourself and Vincent Rue?

A. Yes.

Q. Who is Vincent Rue?

A. He is a representative from the Attorney General's Office here at the State of Texas.

Q. How did you come to be acquainted with Mr. Rue?

A. He first contacted me earlier that week representing himself as a person from the Attorney General's Office and asked if I would be willing to serve as an expert witness in this particular trial.

Q. And when you say "earlier that week," you mean the week of June 29th?

A. Yes. That Monday.

Q. What—what do you know about Mr. Rue's background and qualifications?

A. I have no knowledge of his background, only that he is a representative from the Attorney General's Office.

Q. Is Mr.—I believe it's Vincent Rue, Ph.D. Is Dr. Rue a medical doctor?

A. I'm sorry?

Q. Is Dr. Rue a medical doctor, to the best of your knowledge?

A. I don't believe—I don't believe he is.

Q. He has no medical training?

[14] A. I don't know his background.

Q. So looking at this document, does this help to refresh your recollection about what Mr. Rue was writing for you on June 29th, 2014?

A. Yes, it does. Somewhat.

Q. And what was he writing for you?

A. I sent him my original summary of thoughts that I wanted to have written on paper as part of my report after reviewing the information that was sent to me in preparation for this trial and for my testimony. I sent it to him, and he said he would help me in preparing it in verbiage that would be proper for my testimony, as I am not familiar with that. I'm a physician. I don't normally write reports like this. And, therefore, he said he could assist me in that.

Q. Okay. I'm going to show you one—one more document for identification purposes.

Now, this is an E-mail from Dr. Rue to you dated June 30th, 2014, 4:21 a.m.; is that correct?

A. Yes.

Q. Does this document help refresh your recollection—let me ask you one thing: There's an attachment to the document. What is attached to this E-mail?

A. It's one of the first, I think, modifications of my original report that I submitted.

Q. So attached to this E-mail is a draft of the rebuttal [15] report that you submitted in this case; is that correct?

A. One of them.

Q. Did you submit more than one rebuttal report in this case?

A. Well, there were—there was my initial one that I sent to him, and then he sent me—I believe this is one of them. I don't know the exact train of them. I don't have all my E-mails in front of me. But I remember sending him one, and he sent something back and I sent another. So it was one of them.

Q. Did you exchange a number of E-mails with Dr. Rue?

A. I exchanged quite a few that weekend. I don't remember how many.

Q. Have you provided those E-mails to the Attorney General's Office?

A. He has all the E-mails that I have, and those are the ones that were submitted.

Q. Did you provide your E-mails to the Attorney General's Office?

A. I have not.

Q. Were you asked to do so?

A. No.

Q. Does—I'd liked you to read the first paragraph of this E-mail to yourself, please.

THE COURT: All right. To herself will be fine.

MS. TOTI: To herself.

A. (Complies)

[16] Q. Does the first paragraph of this E-mail help refresh your recollection as to whether the information in the rebuttal report was based on material that you sent to Dr. Rue or based on material that Dr. Rue drafted independently?

A. Please repeat that.

Q. Does this E-mail help refresh your recollection as to whether the information in the rebuttal report that you submitted in this case was based on material that you provided to Dr. Rue or, instead, based on material that Dr. Rue drafted independently?

A. I can't tell at this point, at this particular time of this E-mail, where the exact occurrences were, the steps were.

MS. TOTI: Your Honor, I would like to move these exhibits into evidence so that I can question the witness about the content of the E-mails.

THE COURT: Well, which one of the three are you offering?

MS. TOTI: These three E-mails form a chain. I would like to move all three of them into evidence.

THE COURT: Would that be Plaintiffs' Exhibits 211, 212, and 213?

MS. TOTI: Yes, Your Honor. Forgive me. Yes. I'd like to move Plaintiffs' Exhibits 211, 212 and 213 into evidence at this time.

MR. STEPHENS: Your Honor, the State would renew [17] the objection that these communications are privileged under Rule 26(b)(3)(A) as work product between a consulting expert and an agent of the State and privileged communications between a testifying expert and the agent of the State's lawyers under rule 26(b)(4)(C).

MS. TOTI: Your Honor, Plaintiffs maintain this issue has already been decided by Judge Austin. He heard argument on it from both sides. He made a formal ruling. The defendants objected to that ruling. Your Honor overruled those objections. This issue has been heard and decided already.

MR. STEPHENS: Your Honor, Judge Austin entered an order regarding the production of these

documents to opposing counsel that did not cover, necessarily, the use of the documents at trial which we contend is a separate issue.

THE COURT: Well, I'm going to overrule the objection and admit Exhibits 211, 212, and 213 and allow counsel to cross-examine Ms. Thompson because I think it goes to the weight this Court should give her report. So Plaintiffs' Exhibits 211, 212, and 213 are admitted.

MS. TOTI: Thank you, Your Honor.

Q. (BY MS. TOTI) So, Dr. Thompson, very quickly I want to direct your attention back to the one that's been marked as 211. That E-mail dated Sunday—

MR. STEPHENS: Your Honor, could we get a copy of the exhibits that have been entered into evidence?

[18] THE COURT: Ms. Toti, provide copies of the exhibits to the State, please.

(Plaintiffs comply)

Q. (BY MS. TOTI) Dr. Thompson, this E-mail dated June 29th, 2014, time stamp 7:03 p.m. says, "Mayra, I forgot to send this report to you as well. I am still drafting and will keep you posted. Vince." Is that correct?

A. That's what it says, yes.

Q. And on the line that says attachments, it says "Grossman expert report, 6/16/14 PDF"; is that correct?

A. Yes.

Q. So prior to June 29th, 2014, you had not seen the expert report submitted by Dr. Grossman in this case; is that correct?

A. Yes.

Q. Okay. And now if I can direct your attention to Plaintiffs' Exhibit 212, this is a continuation of the prior E-mail chain; is that correct?

A. It's one of the ones that follows, yes.

Q. And in response to Dr. Rue's E-mail to you, you write back and say, "When is the final due? I thought it was today." Is that correct?

A. Yes.

Q. And then Dr. Rue responds and says, "All reports must be submitted tomorrow. Our deadline is to get this done by tonight so the Texas Attorney General team can review prior to [19] submission tomorrow. Six rebuttal reports will be submitted." Is that correct?

A. Yes.

Q. And then you respond, "I will review on the plane since I have saved it to my computer. Do you want me to add more comments after I review his

statement, or shall I just save it for future reference." Is this correct?

A. Yes.

Q. And Dr. Rue responds, "No. Just want you to review. I don't know when you're arriving in Dallas, but I will keep working on your report and send to you in the middle of the night. So perhaps you could review in the morning. Thanks for your patience and kind assistance." Is that correct?

A. Yes.

Q. And did you understand that to mean that you were not expected to review and comment on Dr. Grossman's report prior to Mr. Rue's—Dr. Rue's completion of drafting your rebuttal report?

A. Well, the revision of what I had sent him.

Q. Okay. So now let's take a look at what's been marked as Plaintiffs' Exhibit 213. And this was the E-mail chain between you and Dr. Rue dated June 30th, 2014, time stamped 4:21 a.m. And attached to this E-mail was your—was a draft of your rebuttal report, correct?

A. Yes.

[20] Q. And the first two sentences of this E-mail say, "Mayra, I tried to use as much of your material as I could."

THE COURT: Ms. Toti, it is not necessary for you to read from an exhibit that's in evidence and

is before me because I can read them myself. And this will go a lot faster if you just cross-examine the witness as to what questions you want to ask her on cross-examination as opposed to one or the other of you reading from an exhibit.

MS. TOTI: Certainly, Your Honor.

Q. (BY MS. TOTI) So, Dr. Thompson, this E-mail indicates that Dr. Rue tried to use the material that you sent him but time ran out and, instead, he just used his own material; is that correct?

A. No.

Q. What is incorrect about that?

A. Well, what's incorrect is the fact that you're saying we're using his material only. I sent him an original report that I did after reviewing the first—all the original documents that he gave me. I sat and I read every single one of—every one of them. And after I read them, I actually drafted my own summary of my thoughts and beliefs in my own words.

Now, you have to understand that, as a doctor of medicine and as a surgeon, my expertise is in the practice of medicine and surgery. My expertise is not writing the written [21] reports that you as attorneys do. And in that matter I needed some help, and he offered to help me. It was very obvious when it was first read that my report was not as clear, it may not have been in the right verbiage, and that's where he helped me.

And so when he's talking about this, I understood him to say that perhaps the choice of words I made were not necessarily the best and that he would modify the order of the words and perhaps use a different phrase. But in no way was it meant to either create a statement that I didn't—of a thought that I didn't have and it was in no way meant to replace any thoughts that I had.

Those opinions were rendered after my full and thorough evaluation of what I read in the time that I was given to review it, and he went ahead and assisted me by writing this. He then sent it to me for me to review and for me to change as needed.

Q. And what did you understand him to mean when he said, "I tried to use as much of your material as I could, but time ran out"?

A. Exactly what it says. He used my—the words I typed for him, and he used it in the words that I gave in the way I gave it. I mean, there is nothing unclear about that.

Q. I agree. Thank you.

I'm going to show you one more for identification, Dr. Thompson. Now, can I ask you, you were deposed in this [22] case, correct?

A. Yes.

Q. And your deposition took place on July 14th, 2014?

A. Yes.

Q. Do you recognize this document that I've just provided you with?

A. The E-mail dated Thursday, July 10th? Yes.

Q. And this is an E-mail from Dr. Rue to you with the subject line "articles to review"?

A. Yes.

Q. And it indicates that there are number of articles attached to this E-mail?

A. Yes.

Q. Do you recollect why Dr. Rue was sending you articles to review three days before your deposition?

A. I'm assuming he sent me information that he thought might help me in understanding the background of the case.

Q. So you—you hadn't seen these articles prior to him sending them to you?

A. Not those particular ones, no.

MS. TOTI: Your Honor, I'd like to move Plaintiffs' 214 into evidence.

MR. STEPHENS: Your Honor, the State would make the same objection regarding Rule 26(b)(3)(A) and 26(b)(4)(C) as to this document.

[23] THE COURT: The objection is overruled. Plaintiffs' Exhibit 214 is admitted.

MS. TOTI: Thank you, Your Honor.

Q. (BY MS. TOTI) Dr. Thompson, at the time that Dr. Rue provided you with Dr. Grossman's expert report, did he ask you to read a copy of the amended confidentiality and protective order that was entered in this case?

A. I believe he did, but I don't remember the exact document or what it said.

Q. I'm going to come back to that in a moment.

Okay. I'm going to mark one more—one more of these for identification. Are you familiar with that document, Dr. Thompson?

A. Yes.

Q. Okay. And that's Plaintiffs' Exhibit 215?

A. Yes.

Q. Thank you. And that's an E-mail from Dr. Rue to yourself dated July 24th, 2014?

A. Yes.

Q. And the subject of this E-mail is "Texas case protective order"?

A. Yes.

Q. And the attachment line says, "Texas amended confidentiality and protective order. Thompson signature page for Texas II protective order." Do you see that?

[24] A. Yes.

Q. Does this refresh your recollection as to whether you had been asked to review the protective order in this case prior to receiving Dr. Grossman's report on June 29th, 2014?

A. There's two questions there. I can't—can you restate that question so I can answer it?

Q. Sure. Does this document help to refresh your recollection as to the first time you received a copy of the protective order in this case?

A. Yes.

Q. And when was that?

A. I don't remember the exact date. The only one I remember is this one, but I received it via E-mail. And this particular—well, this one that I received here, I was out of the country. So I got it at some point after the date it was given.

Q. And at some point did you sign an agreement to be bound by the protective order?

A. Yes. Well, I gave the—an E-mail agreement to go ahead and sign it. I couldn't sign it myself.

Q. So you signed electronically?

A. Yes.

Q. And that was subsequent to July 24th, 2014; correct?

A. That I can recall, yes.

Q. But you had received Dr. Grossman's expert report on [25] June 29th, 2014, correct?

A. Yes.

MS. TOTI: Okay. Your Honor, I'd like to move into evidence Plaintiffs' Exhibit 215.

MR. STEPHENS: Your Honor, the same objection from the State.

THE COURT: How can it be possibly the same objection when it's just sending a copy of a document that is on file in this case?

MR. STEPHENS: To the extent it's requesting signature by Dr. Thompson, that a request conveyed from the Office of Attorney General through Dr. Rue—

THE COURT: All right.

MR. STEPHENS: —it's communication involving, potentially, work product.

THE COURT: The objection is overruled. Plaintiffs' Exhibit 215 admitted. It's this Court's ruling that this doesn't really affect work product at all.

Q. (BY MS. TOTI) So, Dr. Thompson, you testified you were deposed in this case on July 14th, correct?

A. Yes.

Q. Did you speak to Vincent Rue on that day?

A. No.

Q. Are you certain you didn't speak to him on that day?

A. I don't believe I did. I don't recall that I did.

[26] Q. You had no telephone or E-mail communication with him on that day?

A. I don't believe I did. If I—if I did, I just don't remember.

Q. And you don't recall whether you spoke to him during the lunch break at the deposition?

A. I did not speak with him at the lunch break. I know that.

Q. Okay. Dr. Thompson, you have an ownership interest in an ambulatory surgical center in Dallas; is that correct?

A. I heard half your question. I didn't hear the other half.

Q. I apologize. You have an ownership interest in an ambulatory surgical center in Dallas; is that correct?

A. No.

Q. Did you testify at you deposition that you had an ownership interest in an ambulatory surgical center in Dallas?

A. No.

Q. Do you have an ownership in any ambulatory surgical center in the State of Texas?

A. No.

Q. I'm going to ask you to take a look at the transcript of your deposition on page 23. Actually, I would like to direct your attention to page 21, line 9. If you'll read the lines beginning from line 9 down to line 20, does that refresh your recollection as to whether you gave testimony at your deposition that you had an ownership interest in an ambulatory [27] surgical center in Dallas?

A. I have ownership interest in North Central Surgical Center, which is—which is a full-fledged hospital, not an ambulatory surgery center.

Q. So you misspoke when you testified at your deposition about this?

A. No. I—I never said it was an ambulatory surgery center. I said it was—it used to be an ambulatory surgery center. But at the time, over a few years now, it's graduated to a full-fledged hospital. But at one point it was an ambulatory surgery center, and I did have privileges at that point. But currently it is a full-fledged hospital. It is not just an ASC.

Q. Okay. I'd like to direct your attention to page 23 of your deposition transcript?

A. Okay.

Q. Beginning at line 3, it says:

"QUESTION: So tell me—tell me—tell me whether you have a financial incentive to refer patients for treatment in your ambulatory surgery center.

"ANSWER: Yes."

A. Yes.

Q. That was your testimony at your deposition?

A. Yes.

Q. Thank you. And you testified at your deposition that you [28] generally used sharp curettage rather than suction curettage when performing a DNC; correct?

A. In a non-pregnant uterus, that is correct.

Q. And sharp curettage is more likely to result in uterine perforation than suction curettage; is that correct?

A. In a—it depends on what it's being used. But if it's in a non-pregnant uterus, sharp curettage will generally not cause a perforation, but it can. In a pregnant uterus, if one uses sharp curettage, it is more likely to perforate than a non-pregnant uterus.

Q. I'd like to direct your attention to page 39 of your deposition transcript.

A. What page?

Q. Thirty-nine, beginning at line 13. It says:

"QUESTION: And sharp curettage is more likely to result in a perforation; is that correct?

"MR. STEPHENS: Objection to form.

"ANSWER: Yes.

"BY MS. TOTI: And just to be clear, when we're talking about perforation, we're talking about perforation of the uterus?

"ANSWER: Yes."

Is that the testimony you gave at your deposition?

A. Yes.

Q. Thank you. And you also testified at your deposition that [29] it is impossible to fully eradicate bacteria from a woman's vagina; is that correct?

A. Yes.

Q. And you also testified that, in your opinion, there is no medical basis on which to distinguish a physician who has active admitting privileges at a hospital from one who has courtesy admitting privileges at a hospital; is that correct?

A. May I refer to the page that you're referring to?

Q. Sure. Let's take a look at page 68 of the transcript beginning at line 15. It says:

"QUESTION: So, in your opinion, there would be no medical reason to distinguish between a physician who has active admitting privileges and a physician who has courtesy admitting privileges; is that correct?

"ANSWER: Yes."

A. So that is my answer, "yes."

Q. Thank you. So, Dr. Thompson, I believe the binder in front of you has your direct testimony in that—in this case; is that correct?

A. I believe it, but I haven't reviewed the whole binder because this is your copy. There were some corrections I submitted. So assuming that those corrections were submitted and this is the copy of what I was given, the answer would be yes.

Q. When did you submit those corrections?

[30] A. I believe I submitted them on Sunday or Monday morning. I can't remember. Either one. It was this weekend.

Q. Well, I believe you testified at the beginning of the day that the testimony in that declaration was a complete and accurate statement of the testimony that you wish to offer in this case. Are you having second thoughts about that?

A. Well, I should have at that point said I haven't reviewed your copy, and it just—I just thought about it right now and I haven't had a chance to look at your copy. But I assumed it was the

corrected copy. And, if it's not, then—then I have to retract that. I'm sorry, but I

Q. Well, do you want to take a moment to review what's in the binder?

THE COURT: No. Why don't you just ask her particular questions that you want to ask her out of her direct testimony. And if what she's looking at is not the way she recalls it, we will take it up then.

MS. TOTI: Okay.

Q. (BY MS. TOTI) Can you tell me what the specific corrections that you made to the testimony were?

A. They are on the errata sheet. However, I recall one of them was—it should have said "suction curettage," but it had something else. Another choice of words.

Q. Dr. Thompson, let me apologize and interrupt you just for a moment. Are you referring to corrections that you made to [31] your deposition transcript or corrections you made to the testimony in the binder?

A. Well, we're going through the deposition, I thought, right?

Q. Okay. So you submitted some corrections to the testimony in the deposition?

A. Yes.

Q. Okay. Can you direct your attention now to what's in the binder?

A. What—oh. Section 1 here?

Q. The section that has your name on it.

A. Tab 1.

Q. Yes. Your direct testimony, Dr. Thompson.

A. My direct testimony—

Q. Yes.

A. —that I've reviewed, that's fine.

Q. Okay. You didn't submit any corrections to your direct testimony on Sunday or Monday?

A. I submitted my final testimony this last weekend after reviewing it.

Q. Okay.

A. And that is the final, and this is the final.

Q. Okay. And that testimony was based on the rebuttal report that you provided in this case, correct?

A. Yes.

[32] Q. And the opinions expressed are nearly identical; is that correct?

A. Yes.

Q. Can you take a look at paragraph 15 of your direct testimony.

A. And that would be on what page?

Q. That's on page 6.

A. Okay. I agree.

Q. So in the second sentence of paragraph 15, you make reference to some recent medical research; is that correct?

A. Are you looking at—are you looking on page 6 of section A, paragraph 15?

Q. That's correct. The second sentence.

A. Okay. Second sentence. Okay.

Q. So there you make reference to recent medical research; is that correct?

A. Yes.

Q. But you don't provide any citations in that paragraph; is that correct?

A. Yes.

Q. And at your deposition you testified that you hadn't reviewed any specific studies in forming your opinions about the recent medical research that you—you referenced in the similar paragraph in your expert report; is that correct?

A. That's correct.

[33] Q. And you couldn't identify any specific studies concerning this recent medical research at your deposition; is that correct?

A. That's correct.

Q. Okay. And at your deposition you were unfamiliar with the methodology used by the Centers For Disease Control and Prevention to collect data about abortion-related complications; is that correct?

A. Correct.

Q. And you admitted that you hadn't reviewed the—the sources that the plaintiffs' expert, Dr. Elizabeth Raymond, relied on in developing her opinions about abortion-related mortality; is that correct?

A. That's correct.

Q. And those sources included publications by the Centers for Disease Control and prevention; is that correct?

A. At the deposition. That's correct.

Q. Right. And you testified at the deposition that you hadn't done any research or investigation to determine whether abortion-related mortality data published by the CDC is accurate; is that correct?

A. I have not.

Q. And you testified at your deposition that you had not contacted anyone at the CDC to inquire about their methodology for collecting data about abortion-related deaths; is that [34] correct?

A. That's correct.

Q. And you testified at your deposition that you haven't done any independent research concerning the CDC's methodology for collecting data about abortion-related deaths; is that correct?

A. I believe so, yes.

Q. And also at your deposition you testified that, prior to submitting your rebuttal report in this case, you reviewed only one of the nine articles relied on by Dr. Raymond in support of her opinions concerning abortion-related morbidity; is that correct?

A. Would you point out that statement in the deposition? I don't recall specifically that statement.

Q. Sure. It comes up a couple of times. So let's start with page 88.

A. Okay.

Q. So, actually, let's turn back to page 87, line 24. It says:

"QUESTION: Okay. So did you review the studies cited by Dr. Raymond concerning abortion-related morbidity?

"ANSWER: Not all of them.

"QUESTION: Let's take a look at paragraph 12 of Dr. Raymond's report. Paragraph 12 describes the study conducted by researchers at the University of California at San Francisco. Did you review that study?

[35] "ANSWER: No."

Okay. Let's move on and take a look at next page, page 89, beginning at line 23. Actually, let's begin line 16. The question was:

"QUESTION: Okay. So if that's true, California's Medicaid program would have a complete record, both of abortion procedures that are performed for eligible women and any subsequent medical treatments that those women obtained within a six-week period; is that correct?

"ANSWER: I can't say it's correct because I haven't read the study. I don't know the details. I don't know the requirements. I don't know the reporting. I don't know any of the details, so I cannot agree to that.

"QUESTION: Exactly. So you have no basis on which to criticize the methodology of the study?

"ANSWER: I have not read it, no."

Is that the testimony at your deposition?

A. Yes.

Q. So would you—does this refresh your recollection, that at the time of your deposition, which was well after you had submitted the rebuttal report in this case, you had not read eight of the nine studies relied on by Dr. Raymond?

A. As stated in my deposition, that is correct.

Q. And you told the truth at your deposition; is that correct?

[36] A. Yes.

Q. Because you were under oath?

A. Yes.

Q. Okay. And at your deposition do you recall giving testimony about the guidelines for office-based surgery published by the American College of Surgeons?

A. Yes.

Q. You had cited those—excuse me.

You had cited those guidelines in your rebuttal report; is that correct?

A. Yes.

Q. And you testified at your deposition that you believe these guidelines are consistent with prevailing standards of care; is that correct?

A. I hear half of your question because it's not coming through.

Q. I'm sorry. Let me try the other mic.

You testified at your deposition that you believe these guidelines are consistent with prevailing standards of care; is that correct?

A. Yes.

Q. Okay. Dr. Thompson, I'm going to show you what's been marked for identification as Plaintiffs' Exhibit 29. Is that a copy of the guidelines that you relied on in forming the opinions expressed in your rebuttal report?

[37] A. I didn't hear what you said before "rebuttal report."

Q. Are those the guidelines from the American College of Surgeons that you relied on in your rebuttal report?

A. Yes.

Q. Did you review those guidelines prior to the submission of your rebuttal report?

A. Yes.

Q. How did those guidelines come to be in your possession?

A. Through the publication as a reference—I mean, through the Internet. You print them.

Q. So you obtained those on your own?

A. Yes.

MS. TOTI: Okay. Your Honor, Plaintiffs' would like to move into evidence Exhibit 29.

MR. STEPHENS: No objection, Your Honor.

THE COURT: Plaintiffs' Exhibit Number 29 is admitted.

Q. (BY MS. TOTI) Dr. Thompson, do you recall testifying at your deposition that, in your opinion, not all physicians need to have admitting privileges at a hospital within 30 miles of where they practice?

A. That all admitting physicians have to have—go ahead. Say it again.

Q. Do you recall testifying that it was your opinion that not all physicians need to have admitting privileges at a hospital [38] within 30 miles of where they practice?

A. Yes. That's correct.

Q. And you testified that, for some physicians, it's sufficient for them to be able to refer a patient on to a specialist in the event the patient needs care that the physician can't provide; is that correct?

A. Yes.

Q. And you testified that, in those situations, continuity of care can be maintained by direct communication between the treating physician and the referring physician by telephone; is that correct?

A. Yes.

Q. Thank you.

MS. TOTI: I have no further questions for this witness, Your Honor.

THE COURT: Mr. Stephens, redirect?

REDIRECT EXAMINATION

BY MR. REASONER:

Q. Dr. Thompson, did your communication with Dr. Rue influence your opinions in this case at all?

A. No.

Q. Did your communications with Dr. Rue change the ultimate opinions you've offered in this case?

A. Have my communication with Dr. Rue done what?

Q. Changed the ultimate opinions that you've offered in this [39] case?

A. Not at all.

Q. And are the statements and opinions offered in your direct testimony your opinions and yours alone?

A. Yes. Absolutely.

Q. And do you stand by those statements and opinions today?

A. Yes, I do.

Q. Dr. Thompson, are you familiar with the E-mail that I have just handed you?

A. Yes, I am.

Q. And could you describe the E-mail?

A. The E-mail is the first E-mail that I recall receiving from Dr. Rue the day that he first contacted me about this particular trial.

MR. STEPHENS: Your Honor, I would like to move for admission of this document as Defense Exhibit 211.

THE COURT: No. You don't want to make it defendants' exhibit if you're offering it.

MR. STEPHENS: Defendants' Exhibit 211?

THE COURT: All right. Defendants' Exhibit 211. All right.

MR. STEPHENS: Your Honor, and in offering this document, we're preserving our objections regarding communications between Dr. Rue—the objections we previously made and the testifying experts.

[40] THE COURT: Well, I recognize your statement. We'll let the appellate court work that out.

MR. STEPHENS: I understand.

THE COURT: Is there an objection to the E-mail.

MS. TOTI: No, Your Honor. I mean, it's technically hearsay, but we won't object to it.

THE COURT: All right. Defendants' Exhibit Number 211 is admitted.

Q. (BY MR. STEPHENS) Dr. Thompson, does Defendants' Exhibit 211 reflect your understanding of Dr. Rue's role in this litigation?

A. Yes.

Q. Could you describe for the Court the basis for your opinions in this case?

A. I have been in the practice—first of all, I'm board certified in obstetrics and gynecology and have been so since about 1987 I completed my training in 1984, where I did a full-fledged residency. During that time I was trained and developed an understanding of the female anatomy and the complications inherent with the procedures of female genital system.

I very early on discovered the possible life-threatening complications of any surgical procedure on the uterus, not only in the field of pregnancy, but also in the non-pregnant state. Throughout this time I have further [41] experienced more procedures. And in that—in that regard, I have then developed a very strong belief that this is a procedure that needs to be performed in the utmost safe environment for the patient. And that is why I have testified about the need to do these procedures in a very well-regulated and safe environment.

I've had these opinions for a long time. And every day as I practice medicine, I continue to find that these beliefs are further strengthened by day-to-day care of the female patient.

Q. And why don't you publish a lot of articles or studies?

A. In the field of medicine, there are two types of physicians. The first type, as—and, as you know, I work at an academic institution. I'm an associate professor of the University of Texas Southwestern in Dallas. We have a very well-known medical school and, in this regard, we train a lot of physicians.

When you go into medical school, you have two sets of physicians, the physicians that are mainly involved in research, obtaining of scientific data, and publication. Then you have the set of physicians that actually take this information, and they take—they train the physicians in the actual care—clinical care of the patient.

I happen to be involved in the clinical care of the patient. I spend hours and hours of the day taking care of [42] patients. Therefore, I do not publish a lot of peer-review articles because I actually take the information and I apply it to the care of the patient. In fact, my colleagues who do publish a lot of times rely on the information that I give them and the statistics that I provide by performing these procedures in order to come up with their recommendations and their results and their statistics. Interestingly enough, a lot of the reporting agencies rely on our reports. And we well know that, unless we have thorough reports, their data may be faulty. But we try our best to provide them with this report.

My particular practice is the latter. I am a clinician. I see patients every day. I operate at least two full days a week, and I involve myself in the training of medical students.

MS. TOTI: Objection to the narrative, Your Honor.

THE COURT: That's overruled. She's just stating her background and basis of her opinion. You may proceed.

A. And in the process of practicing medicine, I also take care of emergency patients with my residents as well some that I see myself. And I see day-to-day complications of procedures that are done not only in our institution but other institutions.

I have developed those opinions based on my over 30 years of experience in the actual practice of medicine and not necessarily by sitting in an office reviewing articles and [43] punching numbers into a computer and coming up with statistics that rely on someone else's work.

Q. Thank you, Dr. Thompson.

MR. STEPHENS: No further questions, Your Honor.

THE COURT: Further cross, Ms. Toti?

MS. TOTI: Very briefly, Your Honor.

RECROSS-EXAMINATION

BY MS. TOTI:

Q. Dr. Thompson, do you think all medical patients should be entitled to the same high standard of care that you want for abortion patients?

A. I feel—yes. I feel that all patients should have the highest available to them.

MS. TOTI: Thank you. No further questions.

THE COURT: Anything further, Mr. Stephens?

MR. STEPHENS: No, Your Honor.

THE COURT: You may step down.

THE WITNESS: Thank you.

MR. STEPHENS: Your Honor, if the witness has testified that the statement—the direct testimony is true and accurate, do you want a signed copy of that for the record or is that testimony sufficient?

THE COURT: The testimony is sufficient.

MR. STEPHENS: Okay. Thank you, Your Honor.

MS. TOTI: Your Honor at this time Plaintiffs renew [44] their objection under *Daubert* to the reliability of this witness's testimony.

THE COURT: The objection is overruled. The Court finds that the—any questions about the report go to the weight, not the admissibility. She has explained on the stand what parts of the report she enlisted the aid of Dr. Rue on. I have heard her testimony, and I will apply it to the weight that I give that testimony in that report. So the objection is overruled.

MR. STEPHENS: Your Honor, and just so it's clear, the direct testimony is admitted in the record?

THE COURT: The direct testimony is admitted into evidence.

MR. STEPHENS: Thank you.

THE COURT: And I will apply the appropriate weight to it.

MR. STEPHENS: Thank you, Your Honor.

MR. VARELA: Your Honor, Enrique Varela with the Attorney General's Office for the defendants. And at this time we call Dr. James Anderson to the stand.

(Witness sworn)

* * *

[45] JAMES C. ANDERSON,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. VARELA:

Q. Good afternoon, Dr. Anderson. Would you go ahead and please introduce yourself to the Court.

A. Dr. James C. Anderson.

Q. And would you please take a look at the binder sitting next to you. I believe it's tab number 2.

A. There are some E-mails here from Mayra Thompson.

Q. No. It's the binder that says "Direct Testimony." It might be that.

A. Expert Witness Direct Testimony.

Q. Yeah.

A. Okay. And tab 2?

Q. Yes, sir. It should be titled James Anderson, M.D. Direct Testimony; is that correct?

A. It is.

Q. Did you review that?

A. I did.

Q. Okay. Are the statements in that document true and correct?

A. They are, yes.

Q. Are the opinions expressed in that document yours?

A. Absolutely.

[46] Q. In preparing that document, did you have any communications with Dr. Vince Rue?

A. Yes. I've worked with Dr. Vince Rue as a liaison with the Attorney General's Office of Texas, and I look at him as an asset. He helps me wordsmith a document and research articles. But he's a liaison between me and Attorney General's Office and the attorneys there.

MS. TOTI: Objection, Your Honor. We understood that direct testimony was going to be coming in by declaration in this case and that if the declaration was offered, no additional direct testimony would be proffered.

THE COURT: Mr. Varela?

MR. VARELA: Yes, Judge. No. I did not understand that I could not go into some basic background on Dr. Anderson.

MS. TOTI: Your Honor, we had an agreement at the pretrial conference.

THE COURT: Well, at the pretrial conference you had an agreement to use declarations, and there was also discussion that I remember quite well at the pretrial conference over the fact that it would need to be supplemented somewhat. I'm going to overrule the objection and allow Mr. Varela to get the background information. But if he intends to go into any other substantive matters before your cross-examination, I will not allow him to do so.

MS. TOTI: Thank you, Your Honor.

[47] THE COURT: You may proceed, Mr. Varela.

MR. VARELA: Dr. Anderson, did your communications with Dr. Rue influence you at all in your ultimate opinion?

A. Not at all. This has been my opinion ever since I've written it.

Q. And did those communication with Dr. Rue change your ultimate opinion you're offering in this case?

A. Not at all.

Q. The statements that you're making here on direct testimony are yours an yours alone, correct?

A. Correct.

MR. VARELA: At this time I would like to offer Dr. Anderson's direct testimony into evidence.

THE COURT: Ms. Toti?

MS. TOTI: Your Honor, we object to this testimony on the grounds that it's not reliable under Daubert.

THE COURT: And what is the basis for your objection? Daubert covers a lot of the waterfront.

MS. TOTI: Your Honor, we would like to establish a foundation for any objection during cross-examination.

THE COURT: All right. Then I will admit the direct testimony of James Anderson, M.D. That declaration subject to my reconsideration of that ruling if you renew your motion at a later date.

MR. VARELA: Pass the witness, Judge.

[48] CROSS—EXAMINATION

BY MS. TOTI:

Q. Good afternoon, Dr. Anderson.

A. Good to see you again.

Q. Good to see you again.

So Mr. Varela asked you some questions about your relationship with—with Vincent Rue. About how long have you known him?

A. I've talked to him on the phone beginning in 1997. The State of Florida Attorney's General Office asked me to help them with their parental notification law—maybe it was parental consent—in that time period. And Vince Rue was an employee of the Attorney General's Office for the State of Florida at that time as far as I know.

Q. And in approximately how many cases have you worked with Mr. Rue on—or Dr. Rue on over the years?

A. Probably six different cases, six different states.

Q. And have you testified in other cases concerning an admitting privileges requirement for abortion providers?

A. Yes. I've written expert opinion, declarations, and rebuttal reports for four other states on this topic. And I've read, it seems, well over 100 reports between expert reports on both sides. I don't think it's that many, but it just feels like that many.

Q. And so in those cases, the prior cases concerning [49] admitting privileges, what was the process that you went through for drafting your expert report?

A. Well, it started in Mississippi—or the case in Mississippi two years ago. And I was contacted—it might have been the Attorney General's Office; it might have been Vince Rue, because I had worked with him in the Alaska case on parental notification in 2002. And I don't recollect who called me first—if I would write a report about admitting privileges. So I sat down all day on July 4th and wrote my first draft of credentialing and the protective nature that this law would have on the health care of women. On this law it started July 4th, 2012 when I wrote that draft. I remember it well because I told my wife I couldn't go goof off.

Q. And is there a relationship between the opinions that you offered in those cases and the opinions that you're offering here in this case?

A. I think the opinions are identical. I think they're better expressed and organized better, because whenever you do something five times, you just get more clear and you get more precise. And so I would say that the opinions haven't changed at all. The expression of them I hope would have improved.

Q. Who took the primary role in drafting the expert report that you submitted in this case.

A. I've already told you I did it.

Q. And what role did Mr. Rue play?

[50] A. Vince Rue was very much a help in wordsmithing points. He was a help in looking for research documents or supportive documents. As I said in deposition probably 10 days ago, of all the documents, I probably found a third, I have a friend that researched a third of them for me, and Vince Rue probably found a third. But I developed all the points. And then he would help me either wordsmith it, make it clear, or find supportive documents along with what I already had. So that pretty much outlines it.

Everything I do in medicine is teamwork, whether it's in the emergency room, whether it's in the office, whether it's on the 501(c) nonprofit, it's teamwork. And Vince Rue is one of the team players with the Attorney General's Office. So I don't look at it as a

detriment. I look at it as an assistant and asset to help me. There are so many time limitations that we're all plagued by. But, anyway, the opinions were all written by me, submitted by me, and developed by me.

Q. What was the primary means by which you communicated with Mr. Rue?

A. I hate E-mail, but it's necessary. So I'll get 2- or 3-hundred behind. I have some E-mails I never even opened up from Vince. I might scan the subject. But we talk on the phone, we do E-mail, we do text. And when is the Court date, Vince? This logistics liaison was very helpful, too, because when involved with a couple of different states, you've got to [51] plan out your calendar. So E-mail, phone, and text are the three ways—only three ways I know of that we communicate.

Q. And with respect to the E-mails that you sent to Mr. Rue—Dr. Rue—I'm sorry—did you provide those to the Attorney General's Office?

A. I was never asked to. I probably couldn't have because I delete them as time goes on just because the E-mail thing gets so full of E-mails that you never go back and open them up. But I was never asked to.

Q. Okay. But if you were asked to, you would be able to provide those?

A. No.

Q. Why not?

A. I don't keep them. I delete them. I mean, Google has got your trash can. I put them in the trash and then empty the trash can. Now, I keep the reports. I've got my—all my drafts and my reports and I've got the documents that I refer to. But the E-mails, there's no reason to keep them.

Q. Have you destroyed other documents related to your work on this case?

A. I mean, I don't know what you mean by that. I just delete what's trash. And I've got all my reports in all five states and declarations, expert reports, rebuttal reports, and expert reports from both sides. So I have all those. What else is there to keep?

[52] Q. So you were never asked to maintain the documents that you created or relied upon in forming the opinions that you offered in this case?

A. None. Absolutely. But I've got all of the things I've drafted.

Q. Okay. I'm going to mark Plaintiffs' Exhibit 216.

A. You keep more than I do.

Q. I'm a lawyer. It's my job.

So are you familiar with this document?

A. When you talk about this document, you're talking about the rebuttal report of James Anderson or the E-mail?

Q. I'm talking about both. It appears—the document appears to be an E-mail—an E-mail to Dr. Rue from you attaching a copy of your rebuttal report in this case?

A. Yeah. I don't remember it, but I sure accept it as actual sent August 5th.

Q. All right. Can I direct your attention to the page that's been marked in the lower right-hand corner with the number 66030.

A. Yes.

Q. Do you—do you see the paragraph numbered 14? It appears that there was some text and then there was deletion of the text and then there's a parenthetical statement. Do you see that?

A. Yes.

[53] Q. Are you the author of that parenthetical statement in paragraph 14?

A. Yes. I was telling him why I thought it didn't need to be in there because I just felt like it was redundant. At the process I was just making this thing a little bit clearer and smoother to read.

MS. TOTI: Your Honor, at this time Plaintiffs would like to enter Exhibit 216 into evidence.

MR. VARELA: Your Honor, the State objects on the same basis, that this is a privileged communication work product under Rule 26(b)(3)(A) and 26(b)(4)(C).

THE COURT: The objection will be overruled. It's the ruling of the Court that the plaintiffs are allowed to cross-examine this witnesses and attack any report he made on the basis of whether it's his work or not his work. So the objection is overruled. Plaintiffs' Exhibit Number 216 is admitted.

Q. (BY MS. TOTI) Okay. And, Dr. Anderson, just for the record, the date of this E-mail—the bottom E-mail on the chain is June 27th, 2014; is that correct?

A. Yes.

Q. Okay. Now I'm going to show—

MR. VARELA: Your Honor we may get a copy of the E-mail up-front?

THE COURT: Yes. Please provide counsel with a copy [54] of the E-mail.

(Plaintiffs comply)

Q. (BY MS. TOTI) So, Dr. Anderson, paragraph 14, you say in the parenthetical, "Vince, I think this is redundant, but you can overrule me." Is that correct?

A. Yes. This is consistent just with the wordsmithing. we've said that many times. That's exactly what I use Vince Rue for, to help make it

smooth and clear. And if he thought it was that important, that was fine with me. But this is—yes. I agree this is me. But it's very consistent with the wordsmithing that I aim to do.

Q. And, in fact, that paragraph appeared in the final version of the rebuttal report that you submitted?

A. Well, he thought it was important. He thought it was a good statement. So I said, That's fine with me, too. I mean, I'm looking for wordsmithing, clarity, and smoothness. And, you know, we just discuss that. But it's my opinion. I wrote it. It's my opinion.

Q. But Dr. Rue exercised discretion over the final content of your report; is that correct?

A. No. I mean, I definitely am working as a team. When I'm working with a patient, I listen to the other doctors. We bat things around. I listen to the nurses. And so we collaborate, and that's what collaboration is. But as far as saying, Hey, do I need your approval for this, I made the final call. Now, [55] his suggestion was leave it, so I said that's fine. But I wouldn't track that with another E-mail. I hate E-mail. I just talk or text with him or something like that. But this is—this is work I really am glad Vince helped me with as far as wordsmithing it. But he didn't write it.

Q. What was your original understanding of the deadline for submitting your report in this case?

A. I have no idea.

Q. You have no recollection of what the original deadline was?

A. Is this the rebuttal report or the expert report? This is the rebuttal report.

Q. Had you planned to submit more than one report in this case?

A. Well, we had court with Wisconsin at the end of May; we had court with Alabama at the end of May. And I think the expert report for this was due mid June, and the rebuttal report maybe sometime July. I don't know. I mean, but I think that's how it turned out to be, but I don't know the exact dates. And then we had the deposition June 24th, if I'm correct.

Q. Do you understand that the—did you have an understanding that the deadline for submission of your report changed at some point?

A. No. I mean, maybe I did, maybe I didn't. But I don't [56] recall that. Sometimes they do. But when you're dealing with five different states and you're dealing with rebuttal reports and expert reports, it does turn into a soup.

Q. And I believe you testified that you—you didn't identify all of the sources that are cited in your report; is that correct?

A. The Web pages—I did not go to all the Web pages under—I think you're referring to the Susan Anthony list that—when I'm trying to identify the

crack in the system where these laws would help improve health care for women and be protective of women and I had a number of examples of where there was really very poor health care and damage to women, this Susan Anthony list listed a whole group of people, whether it was recording from state reports or medical board reports. So I had not been to all those Web sites to review those. Is that what you're asking me?

Q. Well, what I was actually asking was: Who came up with those sources in the first instance? Whose idea was it to include those sources?

A. Well, in the broad brush stroke, I got a third, my friend who I use who is a quadriplegic and is very good with computer searches got a third, and probably Vince got a third. And when you read expert reports from other witnesses, you can pull expert reports from them.

So, again, on five different states, it turns into a [57] soup who did what and who exactly earned what. But those are the three major players in these expert reports, me, my friend, and Vince. Does that answer your question?

Q. I think so. So the three of you contributed to identifying the sources that—that were relied on in the report?

A. Yeah. And they're all listed there as far as reports. There's nothing to hide there. It's just

Q. And you—it's your testimony that you—that prior to submitting this report, you reviewed some of those sources but not all of them?

A. I didn't review all of the Web pages. And I forget some reports, like this started two years ago in Mississippi when we did our first draft. And, actually, it started 2011. When I was in Afghanistan, the State of Alaska asked me to write a report on the timeliness of intervention for complications. That was real relevant to this. So that was when I decided to work at a combat support hospital in Afghanistan in 2011, and that's paragraph 50 through 57 in the report, all those articles that I researched then in 2011. So this really contains three years. I was in Afghanistan in the summer of 2011, so now we're 2014. So three years of looking for reports.

Q. Okay. And so if you can take a look in that binder in front of you, there should be a copy of your direct testimony [58] there. Do you see that?

A. It says Direct Testimony of Todd Giberson.

Q. I think we want the Direct Testimony of James Anderson.

A. I hope so.

Q. What tab are you under? Tab number 2.

A. Here we go. Yeah. I have it.

Q. Okay. So if you could take a look at paragraph 59 on page 45.

A. Paragraph 59?

Q. Yes. In this paragraph I believe you make reference to that Susan B. Anthony list Web site that you did not have the opportunity to review.

A. Well, I reviewed some of them. Like I said I hadn't reviewed all the—there's two things in here. It says a detailed listing of providers in a summary report as well as there's a mention of a Web site that contains a lot of different examples of state rulings, of investigations, of newspaper reports on that. And so the Web sites I had not—I had not reviewed all of those Web sites to verify every one of those, the credibility. I have since.

I mean, they're all—what I wanted to do in this is just show that this law is necessary; that there's not an accountability out there for the ongoing track record of physician care on this elective abortions. And accountability and this ought to be protective, and this is just showing that [59] the crack exists in the health care system and validates the need of the law. But this isn't—I mean, my opinion is all prior to that. This just kind of supports why we need the law.

Q. And you're familiar with the Susan B. Anthony list?

A. Yes.

Q. And they're a political action committee whose focus is to elect candidates to office that oppose legal access to abortion; is that correct?

A. You know, I don't know that. I haven't investigated it. But I just know it's a pro-life organization, so it doesn't surprise me. I mean, if you say that's true, I believe you.

Q. Okay. You understand them to be a pro-life organization?

A. Yes. Like I said.

Q. Okay. And did you make any effort to verify the underlying reports that you said are captured in this fact sheet that come from newspaper articles and Web sites?

A. Well, yes. I didn't do them all. But when they have—I mean, like with Nicola Riley, when you're looking at the State Board of Maryland's final report in 2012 that barred her from practicing medicine in the State of Maryland, that's from the State of Maryland. You look at Gosnell, and he's been convicted or Steve Brigham.

And so there's a number of those names that are familiar, but I did not verify every one of those subjects. But, again, since then, when I've done that, the ones that I [60] didn't do all are consistently showing the need for this accountability. But I had not done every Web site prior.

Q. So as to some of the Web Sites you did not have the opportunity to review them at all—as to some of the information in the fact sheet, you did not have the opportunity to review the underlying sources at all. And as to others, your knowledge is

based on newspaper accounts and other written statements of third parties; is that correct?

A. No. I think I said there are actual state board documents stating the verdict. And then some of them are—I mean, like, you've got the Alabama, one of those things refers there and it shows a list of deficiencies. This is state information. And it's not newspaper and it's not somebody just, you know, presenting it in the light that they want it presented. It's just the state's final verdict in that situation. Or in the case of Steve Brigham being barred and losing his license, these are state accounts.

Now, you didn't say that that clearly in that question. You were asking me a little bit different.

Q. Sure. What I'm saying is you have no direct, personal firsthand knowledge of these things, correct?

A. That is right. I do not have direct, personal firsthand knowledge. I'm relying on the reports that I reviewed.

Q. Right. And you're relying on documents that you read that contain accounts of these things; is that correct?

[61] A. Except for that was some of them, yes. Of those, on the Susan B. Anthony list, it's 30 different footnotes cited. Twenty-five to 26 were either state documents or some official capacity, State Board of Health or, you know, Department of Health or Board of Medicine and Surgery. So just reviewing their thing. It wasn't like a newspaper report. Now,

five—or four to five were newspaper account type reports.

Q. But none of them were sworn statements made in the context of this litigation; is that correct?

A. That is correct. I don't know how I'd ever get it either.

Q. And paragraph 59 makes reference to an Exhibit B. Do you see that?

A. Yes. That's the Susan Anthony list, the examples of substandard abortion practices which I've been referring to.

Q. But there's no Exhibit B attached to your direct testimony; is that correct?

A. I assume there is. I assume. Now—but it's there. I mean, it's supposed to be. Now, in this case I think we didn't submit a direct testimony. I think we submitted a rebuttal report. So this probably wasn't submitted as far as going in the hopper. But you have it here, so I guess it was submitted.

Q. And when you say "we," who are you referring?

A. Well, again, Vince is a team player with the Attorney General's Office. And I don't call the attorneys in the Attorney General's Office. Vince is the liaison. He tells me [62] when there's a court date, when there's a deposition, and when different articles are utilized. When I deal with the Attorney General's Office, it's just—that would be very complicated.

They've got to give me somebody to network with. So in this case Vince is an employee of the Attorney General's Office. But the Attorney General's Office, as far as I know, didn't submit a direct report. But it's their call.

Q. But you had had discussions with Dr. Rue about submitting a direct report?

A. He is a teammate. Absolutely.

Q. And at some point you intended to submit a direct report?

A. I prepared it for just that. But the Attorney General's Office made that call.

Q. And at the last moment they decided to hold on to that report and submit it as rebuttal report, correct?

MR. VARELA: Objection, Your Honor. That's work product.

A. I have no idea. I just know that it didn't get submitted. And that's the answer, maybe, why that Susan B. Anthony list—I mean, that was just in answer to your question, why that wasn't there.

Q. To the best of your recollection, other than the missing Exhibit B, is this—

A. I don't think it's missing. It's supposed to be attached. When you say it's missing, that's your opinion.

[63] MR. VARELA: Your Honor, I object. This—what they're discussing is work product.

THE COURT: I'm going to overrule the objection on the work product basis. You have introduced the document, and I have admitted it, the Direct Testimony of James Anderson, M.D. And on page 45 in paragraph 59, which is where Ms. Toti is cross-examining, it specifically states that he expanded the Susan B. Anthony list and it is attached as Exhibit B entitled Examples of Substandard Abortion Practices.

I do not find an Exhibit B attached to this direct testimony that specifically refers to it. I'm going to allow her to explore this with the witness as to why it's not there.

MR. VARELA: I might be mistaken, Judge, but my understanding is that they're asking about the legal strategy and they're discussing not just the rebuttal report.

THE COURT: I understood her to be asking him where Exhibit B was and why it wasn't there. And it's his report, and he says it has an Exhibit B to it and the Exhibit B is not there. I'm going to allow this line of questioning. The exhibit is overruled—I mean, the objection is overruled.

MS. TOTI: Thank you, Your Honor. I'll try to be quick about it.

Q. (BY MS. TOTI) Dr. Anderson, so do you have an understanding about whether Exhibit B has been

withdrawn, or did you intend to submit an Exhibit B along with this report?

[64] A. It was submitted in the rebuttal report. I've been talking about it for the last five minutes, the Web sites. Of the 30 citations, 25 are just reporting on what different rules have been made. So the fact that it's not there is a surprise to me. But I know it's been submitted. We talked about it at deposition extensively, and I've referred to it in my rebuttal report. So it's there.

Q. And who created Exhibit B?

A. Well, that's—that did—Vince helped me with that one. I said, I don't know of a lot of these cases beyond the ones that are very—this goes back either North Dakota or Mississippi six months, 12 months, almost two years ago.

But it's a pro-life organization. So you know you risk the bias of it, but it still shows the crack in the system that validates the necessity of a law to protect women from doctors that are unqualified to do procedures that they're doing. So I was fine about it when Vince showed me about it, and I have consistently allowed it to be a part because I think it validates the need for this law.

Q. So, initially, you didn't have a lot of knowledge about the matters that were discussed in Exhibit B, but Mr. Rue explained it to you and provided some of the sources?

A. As any good teammate, we collaborate, we talk, and I give, and we build, you know, a consensus. And that's what teamwork is. So every research thing I've done, every patient care I've [65] done, when it's critical situations, I'm working with people, they're giving opinions. It's a balance. So I would say yes to what you're saying. But there's nothing there I'm trying hide whatsoever.

Q. I understand. And so, Dr. Anderson, you're a medical doctor, correct?

A. Thirty-five years.

Q. And what are your areas of specialty?

A. I'm boarded in emergency medicine and family practice. I got boarded in family practice in '81, and I was boarded in '96 in emergency medicine.

Q. And in the course of your medical practice, you wouldn't typically rely on newspaper articles as an authoritative source. Is that fair to say?

A. Well, in today's world newspaper articles precede reports. So newspaper articles in this information age come out about drugs long before I heard about them. Now, I don't start using them based on newspaper articles, but I am aware of them. And it does put them on my landscape when a drug is all of a sudden in newspapers. Just like your statins are having liver effects. I'll see that long before I'll see it in the medical reports. And it does impact me because I know they're getting their information from somewhere.

Now, I'm not saying I build my whole case on it. But whenever you see something, you process it and you look at it [66] and you try to validate whether it's worth giving credibility to or not.

Q. Sure. But you don't believe everything you read in the newspaper?

A. You know the answer to that. No, I don't.

Q. Okay. And so, Dr. Anderson, you don't have any experience as an abortion provider, correct?

A. No, ma'am, I do not.

Q. And, in fact, you have some objections to the provision of abortion care. Is that fair?

A. Well, I like what President Clinton said. He hopes there's a day we never have an abortion. But while they're there, let's make them as safe as possible.

Q. And would it be fair to say that many of the opinions that you offer in this case are based on opinions that you have offered in prior cases dealing with the admitting privileges issue?

A. You mean Alabama and Mississippi, et cetera?

Q. Yes.

A. Yes. It's the same.

Q. And a lot of the opinions you offer are based on your firsthand experience. Is that fair?

A. In the emergency room, yes.

Q. And many of the opinions recount conversations that you've had with colleagues, although the colleagues aren't identified; [67] is that—

A. Well, I identified them in deposition, but yes. I mean, I've had a lot of colleagues over the last 35 years that I've shared opinions with.

Is that box all about me?

Q. No. Don't worry. I've just got one more.

A. You and I go back a long time.

Q. I just need to put my hands on the right piece of paper.

A. If you're pulling back papers from where we started, I'd say, Oh, my gosh.

Q. No. There's a reason that nobody likes lawyers.

Okay. Dr. Anderson, I'm going to mark one more exhibit. I believe we're up to 217?

THE COURT: That's correct. We will be if you mark something 217

MS. TOTI: I'm going to mark this one 217.

Q. (BY MS. TOTI) So, Dr. Anderson, one of those prior cases that you testified in concerning admitting privileges was a case out of Alabama; is that correct?

A. This is correct.

Q. And to the best of your knowledge, was that case titled *Planned Parenthood Southeast, Incorporated v. Luther Strange*?

A. Yes.

Q. And are you aware that a decision was issued in this case earlier this week?

[68] A. They told me this morning when I met at the Attorney General's Office that—

MR. VARELA: Objection, Your Honor. That's privileged.

A. I heard about it this morning.

Q. Fair enough.

THE COURT: I really don't think it would be work product if you told him about an opinion that was a public opinion that had been published and released by the Middle District of Alabama, Mr. Varela. I don't think that's what we seek to protect.

MR. VARELA: No, Judge. I understand, Judge. But if we're going to go into the contents of our conversation, that's my objection. I just wanted to

THE COURT: Thank you.

Q. (BY MS. TOTI) And, Dr. Anderson, you testified as an expert in that—in this case; is that correct?

A. Yes.

Q. Okay. So I'd like to direct your attention to page 140 of this very lengthy decision. And I'm going to direct your attention to footnote 24 which states, "Drs. Thorp and Anderson each opined that the proper care for even the simplest complication would require detailed knowledge about the patient's history, reproductive goals, and other information. However, the Court discredits Dr. Anderson's testimony on this [69] point due to concerns about his judgment or honesty, as described in the forthcoming supplemental opinion. The Court discredits Dr. Thorp's opinion on this point because it is inconsistent with his own practice, as described below."

Did I read that correctly, Dr. Anderson?

A. Yeah. But I—it doesn't say I'm very complimentary.

Start off again, because I never—you said footnote 24?

Q. That's right, Doctor.

A. All right. I don't have footnote 24 in front of me. Let me look at that. I've got 25 in front of me. What page did you say?

Q. I'm on page 140.

A. Page 140. All right. Okay. There you go.

Q. If you'll just take a moment to look at it, my only question is whether you understand yourself to

be the Dr. Anderson that's referred to in that footnote?

A. Now, what are you saying about that that wasn't very complimentary? I still hold that opinion.

Q. I'm sorry about that. I'm asking if you understand yourself to be the Dr. Anderson that's referred to in that footnote?

A. I am.

Q. Okay. Thank you.

MS. TOTI: I have no further questions for this [70] witness.

THE COURT: Redirect?

MR. VARELA: Yes, Judge.

REDIRECT EXAMINATION

BY MR. VARELA:

Q. Dr. Anderson, you said you've worked with Dr. Rue since 1997, correct?

A. Correct.

Q. But that you've been a practicing physician, both as an emergency room doctor and in your own family practice, for 35 years?

A. Yes.

Q. How long have you been an advocate of continuity of care, doctor-patient trust, communication,

essentially the foundation—foundational principles of patient-centered health care system?

A. That's probably one of the reasons I went into primary care. So I would say this has been a big part of my life in choosing family practice back in medical school, because of the continuity of care. So it dates right at the beginning of my medical career.

Q. So the opinions you have in this case are the opinions you've had well before you met Dr. Vince Rue, correct?

A. Correct. I actually—I was in the—I was involved in a lot of different legislative initiatives in the Virginia [71] General Assembly relevant to my emergency room practice, so that was probably 10 to 15 years before I ever talked to Vince Rue that I was writing these opinions.

Q. All right. Now, I want to change gears a little bit with you. What, if any, experience do you have treating patients who have experienced complications from abortions that require emergency room management?

A. Over that 22 years in the emergency room, I would say very many. My last time—my record says I resigned from the emergency room in 2005 due to my commitment to the Army. And so up through '84 to 2005 or '83 to 2005 when I was part-time in the ER, so 22 years, I've seen very many complications.

Q. What kind of complications do you see in abortion?

A. You see the short term, many of them very minor—bleeding, pain, low-grade infection. They can be treated with reassurance or antibiotics or just simple maneuvers. And that's the majority, thankfully. But then you have the short-term complications of severe infection—I mean, when I say short-term, anywhere from 24 hours to two weeks—and severe infection or persistent bleeding. It can be major complicating infections.

So, typically, your bleeding, infection, anywhere from immediate to two weeks. And then you have your long-term complications—the psychological impact. Some women regret having abortion. It kind of gets in a soup with depression and [72] guilt. Some women, actually, if you've had an abortion infection, you can have infertility. So some women I'll see later, and that's your long-term effect. So depression, guilt, and sometimes infertility.

And those are—the infertility isn't really due to the abortion. It's due to the complication of abortion, if a woman had infection, it went up the fallopian tubes and scarred them.

Q. What is your opinion regarding the reasonableness and the necessity of the HB 2 provision that the plaintiffs are disputing in this lawsuit?

A. I believe HB 2 is very reasonable and necessary. It provides safer abortion care for women who undergo elective abortion. There are three majors reasons for this.

Q. What are those?

A. In a patient-centered health care system, clinical outcomes and patient safety are your top priority. So the three reasons that impact patient outcome and patient safety, first is that the hospital privileging of a physician is a close, scrutinizing process to make sure the physician is well trained, has the technical skills, and the track record to do the procedure that he or see is advertising themselves to do on patients. So it's a protective scrutiny so physicians aren't doing things they're not qualified to do.

Secondly, with the hospital privileging, there are [73] mandates for accessibility and availability of the physician that come with the privileges. And this accessibility and availability, what that does is improve continuity of care. That continuity of care affects information, it affects management decisions. And it's the continuity of care relationship, knowing patient preferences. So the continuity of care has been associated with much better clinical outcomes in patient safety.

Also with the availability and accessibility standards that admitting privileges brings with it, you have better doctor-patient communication because the doctor is available and accessible. He's not flying in or he or she is not moving in and out of state. They're accessible for communication with the patient. But they're also accessible for communication with consultants. And communication errors now are

in the top 80 percent cause of medical errors. Communication is a huge issue.

And, lastly, it's the time delays. With no communication you're always forced into unnecessary time delays that can be very life-threatening if it's a severe infection or hemorrhaging. You could lose a patient in an hour, which I've seen.

THE COURT: At this time we'll take our afternoon recess. We'll be in recess for 15 minutes.

(Recess)

[74] (Open Court)

THE COURT: Mr. Varela, you may continue.

MR. VARELA: Thank you, Judge.

Q. (BY MR. VARELA) Dr. Anderson, we left off, and I believe you answered the question. Let me move on to ask you, what are the foundational principles of patient-centered health care systems that you talked to—that you spoke of earlier and briefly, please?

A. Doctor-patient trust, continuity of care and communication are the three issues that are foundational principles that I'm referring to.

Q. And what, if any, of these three principles, in your opinion, will improve with this act?

A. I think all three of them will.

Q. How so?

A. What did you say?

Q. How so, if you can explain briefly.

A. Well, the credentialing of doctors makes sure that people aren't there that are unqualified. And that enhances trust, to know that physicians are trained and qualified. Accessibility and availability of the physician improves continuity of care as well as communication. So all three of those are enhanced by this privileging requirement.

Q. You're also a professor of residence; is that correct?

A. Yes, I am.

[75] Q. And with respect to your teachings—to your residents, what is it that you push to your residents regarding trust?

A. Well, it's essential basis. I don't think of the 150,000 patients I've seen, that any of them want a physician they don't trust. It's subterranean. It's part of the system. It allows me the vulnerability of the situation to guide the patient. So I teach them how to develop trust with the patient—communication skills, again, accessibility and availability, having a solid knowledge base. They all go into the creation of doctor-patient trust. It's not static. It grows.

Q. And in this case you've had the opportunity to review and understand the expert reports that were submitted by the plaintiffs, correct?

A. Correct.

Q. And how does your opinion differ from those experts regarding these foundational principles?

A. Well, as I stated in my report, Dr. Fine referred to continuity of care as a single phone call to the emergency room physician, whereas I refer to continuity of care on three different levels. It's not only the information about the patient—the past medical history, allergies, drugs. It's also a management continuity of care where you're involved. Like if a surgeon is involved, you're managing diabetes, hypertension, you know the patient's background there. And, [76] thirdly, it's a relational continuity where you know preferences of a patient.

So one single phone call doesn't at all equate to the continuity of care that most people really desire in their doctor-patient relationship.

Q. Okay. What are the three reasons you opine in your—in your testimony and your report that this act will improve patient safety and clinical outcome?

A. Again, it would be protective of patients to have doctors that were well qualified and scrutinized, make sure their technical skills as well as their track record are up to the responsibility they're doing.

Number two, the accessibility and availability that go along with this act through hospital privileging improves continuity of care because the physician is available and accessible, as well as communication around that patient and with the patient as well as with the other health care team members. So all

three of those areas have been associated with better clinical outcomes and better patient safety.

Q. Okay. Dr. Anderson, let me change gears on you here. I want to talk to you a little bit about abortion safety, the procedure safety, and what your opinion is of the plaintiffs' experts opinion and the data they utilized.

MS. TOTI: Your Honor, I would like to object this is beyond the scope of cross-examination.

[77] THE COURT: Overruled. You may proceed.

Q. (BY MR. VARELA) Do you want me to repeat that convoluted question?

A. My opinion about the safety of abortion?

Q. Yes. In terms of what you've come to understand as the expert's—the plaintiffs' experts opinion regarding and use of the data to complete and come to their conclusion.

A. Well, in my report I only alluded to the area relative to my experience. In the 22 years in the emergency room, I've seen very many complications of abortion but I've never reported one. When I've gone to the Virginia Department of Vital Statistics, there's no record of abortion complications, there's is no mean to report those. Neither is there any requirement. So my experience is it seems a lot more frequent than the numbers they're quoting, but I don't

have any infrastructure and nor have I ever reported a complication.

Q. Is it your testimony that the rate of complication reports are much higher than what the plaintiffs' experts are saying?

MS. TOTI: Objection, Your Honor. Leading.

THE COURT: Sustained. Restate your question.

Q. (BY MR. VARELA) What is your opinion with respect to the amount of complications and the number that plaintiffs' attorneys have opined?

A. It just seems, from my anecdotal experience, that it's more frequent than the numbers I read. But I have no data to [78] validate that. That's why I just say it's related to my experience.

Q. Within your peers, what have you come to learn regarding reporting of abortion complications from ER doctors?

A. Well, the two I refer to in my report is they never have reported one either. One of them—both of them have 60-some years of emergency room experience between them and never once have they reported a complication of abortion because there's no means by which to do that.

Q. What, if any, experience do you have with emergency room patients who come to you with abortion complications and their hesitance to disclose that information?

A. Well, this kind of obscures the data collection as well. I mean, it's a very hard decision. It's a very private decision to have the abortion, and many patients that have had it have not wanted it to be disclosed on their medical record, some of them years prior and some of them at the moment, because it is a source of uncertainty.

And so I don't put it along with the many diagnoses of infection or bleeding secondary to abortion. I'll just put infection or bleeding. Now, it's in the body of my medical note. It has to be. But if you tried to research it and figure out why these patients were there, it would be very difficult to come up with research data that was good.

Q. Okay. Let's change gears just a little bit again. I want [79] to go back and talk to you a little bit more—more about hospital privilege. What—what does the rigorous scrutiny of doctor qualifications translate to regarding patient care specifically to this act?

A. The Joint Commission which is overseeing hospital privileges and mandated in the hospital care and the hospital system has gotten very rigorous at defining the privileging process. It's a two-part process. One is called FPPE, which is a Focused Professional Practice Evaluation, to make sure the physician has the credentials and training and has qualified with the numbers of procedures to do the procedure they're applying for.

And the other one is more of a newer addition to that that's called OPPE, Ongoing Professional Practice Evaluation, so that a physician's track record is evaluated. If a physician's compromised by age or disease or different things, there's some way to identify maybe in the track record for patient safety.

And the heads of services of hospital staff are expected to implement this to rate that two-year process in between the focused practice physician. So you have focused plus ongoing, as mandated by the Joint Commission.

Q. What is your opinion regarding doctors who are unable to obtain hospital privileges?

A. Well, I think that, for the most part, if it's due to [80] training and education and track record, then it's very protective of the patient.

Q. Okay. Drs. Fine, Raymond, and Grossman, have —do they address this issue?

A. They addressed that it was unnecessary. But they didn't address an alternative system to help assure patient safety against doctors who are unqualified. There really wasn't an alternative option that they put forth.

Q. And so, generally, what is your opinion regarding higher scrutiny in hospital credentialing and privileging process?

A. It's protective of patient care and clinical outcomes. It's been pretty well affirmed as well.

Q. Do admitting privileges, in your opinion, the provisions of this act, improve continuity of care?

A. They do.

Q. How so?

A. Because the standards of accessibility and availability that come with admitting privileges.

Q. And are you aware what Dr. Fine opined regarding the continuity of care?

A. Only that he said one phone call to the emergency room physician was continuity of care.

Q. Do you agree with that?

A. No.

Q. In all of your years as an ER doctor and handling abortion [81] complications, how many phone calls have you received from a woman's abortion doctor when dealing with her complications from the abortion?

A. None.

MR. VARELA: Pass the witness.

RECROSS EXAMINATION

BY MS. TOTI:

Q. Okay. Dr. Anderson, just a few more questions. I promise not too long. In your experience as an emergency room physician, is it fair to say that

sometimes patients present at the emergency room that don't actually require treatment?

A. Yes. They need reassurance. They're scared, but they don't actually need treatment.

Q. And so what do you do when—you know, when a patient like that shows up in the ER?

A. Well, I don't think I could say that just by the fact of them walking in. I'm looking at their history, I'm looking at their vital signs, I do a physical examination, and I do lab work. So it's two- or three-hour evaluation to see if there is evidence of an infection or significant bleeding.

And so the lab work and the vital signs and the patient condition are all needed to come to that conclusion that we can just, you know, safely let you go home and watch and procrastinate as far as not having to do a major intervention.

[82] Q. And you would do that kind of evaluation as a matter of course, correct?

A. You really have to because a patient's compensatory mechanisms can cloud the acuteness of the situation so completely that, if you don't rely on physical exam, vital signs, and lab work, you're shooting from the hip too much.

Q. Understood. And your opinions in this case focus on the admitting privileges law; is that correct?

A. That is correct.

Q. You're not offering any expert testimony about the ambulatory surgery center requirement part of the law?

A. No, I'm not.

Q. Okay. And you have no knowledge of the requirements for obtaining admitting privileges at hospitals in and around McAllen, Texas. Is that fair?

A. Only the similar requirements from the Joint Commission that are pretty much a nationwide type of umbrella. But specifically, no.

Q. So you haven't looked specifically into the bylaws of the hospitals in and around McAllen, Texas?

A. No, I have not.

Q. And how about El Paso, Texas? Have you done any research about the requirements for admitting privileges at the hospitals in the El Paso area?

A. I have not.

[83] Q. Are you aware that sometimes physicians are denied hospital privileges for reasons unrelated to their clinical competency?

A. I've heard of that, but I've never experienced it in our hospital system.

Q. So if in fact that were true, that sometimes physicians are denied hospital privileges for reasons unrelated to their clinical competency, would that

undermine some of the opinions in this case? Would that change your mind about some of the opinions you've offered?

A. Not really, because a physician—when you're talking about complications of abortion, a physician can get courtesy privileges and, therefore, not do admissions. But the hospital is available for the care of women that have the complications of abortion. So courtesy privileges and temporary privileges allow for some fluidity in the situation that are good for women and give the doctor an option, but also bring the protective nature of scrutiny of hospital privileges and accessibility and availability.

Q. So you think there's just never an occasion when a physician is denied hospital privileges for reasons that are not related to their qualifications?

A. "Never" is a scary word. I would say the majority—the significant majority is to be very protective and it's going to be a global asset to women and be protective.

[84] Q. But if you were going to make an evaluation on a case-by-case basis, you might need to take into account the particular facts of that case. Would that be fair?

A. There's always individual perspective. I mean, whenever you're dealing with global perspective, you're always dealing with individual perspective. I mean, every one of my patients is unique, and

if I try to cookie-cut them, it doesn't work. They're unique people.

Q. So would it be fair to say that, even if an admitting privileges requirement made sense, you know, as a general matter, in certain particular circumstances, it might not make sense?

A. I don't think I'd say that because right now I still think it's very protective. I would stick by that, globally, it's going to make sense.

Q. Okay. And what—what was your understanding of Dr. Fine's testimony in this case?

A. Well, what I've just testified to, that continuity of care being a phone call to the emergency room physician I disagreed with. He didn't really talk anything about communication, except to mention it maybe once. And there really wasn't much mention of doctor-patient relationship, which is really the meat and potatoes of my report, the importance of the doctor-patient relationship development of trust. So he didn't mention that.

[85] Q. But you—you understood him to say that—that simply one phone call is all that is required to maintain continuity of care?

A. That's what he said.

Q. And that's what your opinion is based on?

A. I mean, that's what I'm quoting him to say about continuity of care, that he said one phone call

was sufficient for continuity of care and, otherwise, accessibility and availability wasn't relevant.

Q. And did you read his report yourself, or did you get an understanding of his opinions from Dr. Rue?

A. Oh, I read it many times. It has kept me up many times.

Q. And his report in this case I'm talking about.

A. Absolutely.

Q. Okay. Dr. Anderson, it's been quite some time since you've treated a patient with an abortion-related complication. Isn't that true?

A. The short-term ones. I still—in my clinical private practice, I have people who have regret or depression over the decision. Now we're talking about a soup. Abortion is just one aspect of the soup. Some people have drug addiction and suicide attempts, abortions, and it gets very complex. But infertility, sometimes people relate that. But I do not have the short-term complications of bleeding and infection because most of my—most of the ladies in today's health care [86] industry want to go to ladies, especially young ladies. And I'm really not a young lady physician.

Q. I still like to claim to be a young lady even though I might be getting a little bit past that now.

So, Doctor, would it be fair to say when you talk about the abortion-related complications that you're

frequently treating, you're talking about what you perceive to be long-term complications of abortion; is that right?

A. Well, I mean, I refer to the years from '83 to 2005. I mean, that's the short-term complications. But since then, when I resigned from the emergency room in 2005, really, it's the Army practice, the abortion issue, and the issue overseas and my clinical practice here in Richmond, Virginia.

Q. So in terms of the physical complications of abortion, things like bleeding and infection and so on, you're relying on your experience from the early 1980s to form your opinions in this case; is that right?

A. '80s through 2005, and hemorrhage and infection I see all the time still, but not related to abortion. But I see the consequences of hemorrhage and infection in my practice.

Q. Well, when you say the consequences of hemorrhage and infection, what do you mean by that?

A. Well, you have people that will have a GI bleed and they're vomiting blood. They drop down their blood count, and I'll be treating hemorrhaging there the same as I would be [87] treating hemorrhaging from a young lady as far as uterine bleeding.

Now, I'm getting different subspecialists. I'm doing transfusion or fluid replacements. And when I'm overseas and dealing with soldiers that have been wounded, I'm treating hemorrhaging the same way. So hemorrhaging, knowing the time delay with heavy

bleeding or bloodstream infection is—my back is against the wall on those two situations, whether it's from a complication of abortion or an injury overseas or whether it's an older person. You know, I don't do pediatrics anymore, so that's why I keep referring to older people.

Q. So when is the last time you treated a patient that was experiencing hemorrhage as a result of an abortion procedure?

A. It was before that time period in 2005.

Q. Sometime before 2005?

A. Yes.

Q. And nothing since then?

A. Yes. You're correct.

MS. TOTI: No further questions for this witness.

MR. VARELA: Nothing further, Judge.

THE COURT: All right. You may step down.

MS. TOTI: Your Honor, the plaintiffs wish to renew their objection both to the report as a whole and—I'm sorry—to the testimony as a whole and to paragraph 59, in particular.

[88] THE COURT: The Court has considered the objection and has considered the testimony of Dr. Anderson in its entirety. The objection is

overruled. However, there is no—the Court observes there is no Exhibit B attached to the report. So to the extent that Exhibit B would have shed some light and added any weight to paragraph 59, it of course is not present and the Court will not consider it for any purpose.

MS. TOTI: And, Your Honor, we would also move to strike all reference to the Susan B. Anthony list fact sheet in that the witness clearly testified it wasn't based on his own knowledge, he didn't have knowledge of the sources in there, that those sources are all hearsay. And under Rule 703 of the Federal Rules of Evidence, it's not the kind of hearsay that an expert would typically rely on. And he couldn't authenticate it. He said that Vincent Rue created that and said he looked at some of the sources but didn't look at some of the other sources.

THE COURT: Mr. Varela.

MR. VARELA: My understanding is that he did say that he did review them but that he did not review every single one of them. So in order for them to completely strike that portion of it, it doesn't—

THE COURT: An expert's report can incorporate hearsay. It's the conclusions that is drawn—that are drawn by the expert that are important to the Court, not the [[89] particular component parts.

The objections to the so-called Susan B. Anthony list again go to the weight, and the Court will consider the report based on the testimony of Dr. Anderson

in considering the weight in the report. So that objection is overruled also.

MS. TOTI: Thank you, Your Honor.

THE COURT: Ms. Klusmann.

MS. KLUSMANN: Yes. Beth Klusmann with the Office of Attorney General. The State calls Ashton Jimenez.

THE COURT: Pardon me.

MS. KLUSMANN: Ashton Jimenez.

(Witness sworn)

ASHTON JIMENEZ,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. KLUSMANN:

Q. Good afternoon. Could you please state your name for the record.

A. It's Ashton Fisher Jimenez.

Q. And if you don't mind, how old are you?

A. Twenty-eight.

Q. And are you married?

A. I am.

Q. Do you have any kids?

A. I do. I have a son.

[90] Q. And what is your educational background?

A. I have a bachelor of—I have a bachelor of arts in psychology from Baylor University and a master of science in mental health counseling from the University of Tennessee.

Q. And do you work outside the home?

A. I do.

Q. What do you do right now?

A. I'm a licensed professional counselor, and so I do family counseling at STARRY Counseling in Waco, Texas.

Q. And do you do any volunteer work outside of that?

A. I do. I volunteer with Care Net of Central Texas and provide some counseling services for them.

Q. And what specific counseling services do you provide for Care Net?

A. Yeah. I usually help them run their post-abortion groups a few times a year.

Q. And how did you become involved in the post-abortion group?

A. I went through one at one point when I was in graduate school. And so once I finished up my

license or was working on my license out of graduate school, I chose to kind of pass that on and help other women who had wanted to go through that group.

Q. So let me just jump right to it then. You have had an abortion?

[91] A. Yes.

Q. And when was that?

A. It was August of 2004.

Q. How old were you then?

A. I was 18.

Q. And what was going on in your life at that time?

A. At the time that I had the abortion, it was my first week of undergraduate at Baylor University. I was 18. I was—when I became pregnant, I had just graduated from high school.

Q. And what was going on in your mind when you found out you were pregnant?

A. I was scared. I felt like I was letting people down by getting pregnant. And I just kind of kept thinking about, wow, this is going to be a major change in my life, to have a child. And so a lot of selfish things.

Q. How many people did you tell that you were pregnant?

MS. SOIFER: Objection, Your Honor. I'm going to object to this testimony on grounds it's not relevant to any issue in this lawsuit.

THE COURT: What's the issue, Ms. Klusmann?

MS. KLUSMANN: Two, Your Honor. First, Ms. Jimenez testified about her abortion before the Texas Legislature, so they were aware of her story when they were considering House Bill 2. And, number two, I just think we've been discussing this issue in very clinical terms from people who [92] have never gone through the process. And think if we're going to discuss what is required for women in this circumstance, it would be helpful to hear from someone who has actually gone through the process.

THE COURT: Well, with regard to testimony before the legislature, I feel certain it was the Attorney General's Office on the first day of trial that pointed out that there was no issue before the Court as to the reason behind the act.

MS. KLUSMANN: That is correct, Your Honor. I would, however, point out that the plaintiffs have continued to challenge the rational basis for the act, so we are continuing to put on evidence regarding that.

THE COURT: Well, Ms. Soifer, I think you're probably right, except I've allowed the plaintiffs to put on evidence in order to make their bill, and I will allow this witness to testify in response to

the evidence that I have allowed the plaintiffs to put on.

It may or may not affect any issue in this case, but I want a complete record to go to the Circuit Court. So the objection is overruled. You may proceed, Ms. Klusmann.

Q. (BY MS. KLUSMANN) Just back to where we were, I think the question was: How many people had you told that you were pregnant?

A. So the father of the baby knew, and then I told my roommate.

[93] Q. And what made you decide that you were going to have an abortion?

A. I think mostly out of fear and being scared at the time.

Q. So what was the first step you took in that process?

A. I didn't take any steps until I arrived in Waco, Texas. And when I did, I called Planned Parenthood.

Q. And what—what were you told over the phone?

A. They said that I was probably nearing eight weeks and that I needed to come in in the next day or two to get the procedure done.

Q. And did you go to the appointment?

A. I did.

Q. And who did you speak to at the Planned Parenthood clinic?

A. I remember speaking to a female. I don't remember if she identified herself as a nurse or a doctor. And she completed an ultrasound, said that I was pregnant, and then talked to me just about the pills and provided those.

Q. So you were going to have a medication abortion?

A. Yes.

Q. As opposed to a surgical abortion?

A. Yes.

Q. Okay. So I think you said—did you tell anyone you intended to have an abortion?

A. Sorry. Just ask again.

Q. I apologize. I think I already asked this question, but [94] did you tell anyone that you were at that time going to be going through an abortion?

A. Yes. So prior to that I had only talked to the father of the baby. And after that appointment, I talked to a roommate.

Q. Okay. Did you take the pills at the Planned Parenthood clinic?

A. I did not.

Q. Where did you take them?

A. In a dorm room at Baylor.

Q. Okay. Did the clinic identify any safety precautions or warnings that you should be aware of when you took the pills?

A. No.

MS. SOIFER: Your Honor, I'm going to object to this hearsay from 10 years ago.

MS. KLUSMANN: Your Honor, we're not offering it for the truth, but just to explain what her state of mind was when she was taking the pills.

THE COURT: Well, re-ask the question.

MS. KLUSMANN: Sure.

THE COURT: I think this is a close call on whether we can correct it by merely saying that it's not being offered for a certain purpose. If it's just pure background, that's one thing. But re-ask your question.

Q. (BY MS. KLUSMANN) What was your understanding of what was going to happen when you took the pill?

[95] A. I didn't really have a good understanding. I was thinking some mild cramping. They didn't really talk to me a lot about what was going to happen. And they did provide me with hydrocodone to take when I took the pills to perform the procedure,

and that was really all I was given. So I knew there could be some pain but wasn't sure what kind of pain to expect.

Q. And what happened after you took the medication?

A. After I took the medication, it was probably 20 minutes, and then I began having excruciating pain. I was leaning over my dorm bed. I would say on a scale of one to ten, probably a nine or a ten. It was the kind of pain where you really can't think straight. You're just trying to kind of get through it. Light-headed, dizzy, feeling kind of faint.

Q. And was your roommate around to assist you?

A. She was. She saw the level of pain I was in, and I think she didn't expect it because I hadn't told her I didn't know to expect it. And so she went and got another friend that we had, and I can remember them both standing at the door trying to figure what we should do. They were scared.

Q. What happened after the pain, I assume—yeah. Sorry. I'll just leave it at that. What happened after you started feeling the pain?

A. Yeah. So I spent some time in the room. And, again, I wasn't like—I wasn't really able to talk with them or [96] communicate with them. I remember them standing at the door and kind of discussing if they needed to talk to anyone else about what was happening. And then at some point I went down the

hall to a dorm bathroom. And in that bathroom there was a lot of pain, dizziness, lightheadedness, I started bleeding heavily. And at some point I passed the baby.

Q. And were you expecting that amount of bleeding?

A. I wasn't.

Q. Did the bleeding end that day?

A. It continued for a few weeks afterwards.

Q. And did you go back to the clinic to follow up after your procedure?

A. They had scheduled a follow-up appointment, and I inquired about the bleeding at that appointment.

Q. And what was your understanding afterwards about your continued bleeding?

A. I didn't get a lot of feedback on that, except I shouldn't worry about it.

Q. And have you since learned whether your experience was unusual?

A. I'm sorry?

Q. Have you since learned whether your experience was unusual, or was it more par for the course?

A. From what I've heard, working at a pregnancy resource center and just kind of hearing other women's stories, it [97] sounds like that was—

MS. SOIFER: Objection, Your Honor.

THE WITNESS: —par for the course.

MS. SOIFER: This calls for hearsay.

THE COURT: Sustained as to hearsay.

Q. (BY MS. KLUSMANN) All right. I'll just move on then.

Short of switching subjects again, this is not the first time that you have told this story publicly, correct?

A. Correct.

Q. And you testified about your experience before the Legislature?

A. I did.

Q. When was that?

A. It was first Senate Bill 97. I want to say it was a year and a half or two years ago.

Q. Okay. And why did you decide to testify?

A. I know my story was—it was relevant to that bill. And they requested, and I didn't mind sharing that information to help the bill.

Q. Now, you understand that this lawsuit concerns what we're calling admitting privileges and ambulatory surgical centers?

A. Correct.

Q. What is—you're not claiming to be an expert on any of that, right?

A. No.

[98] Q. What is your general understanding of admitting privileges?

A. That a doctor would be affiliated with a hospital; that they would be a part of the—recognized at the hospital as one of their physicians and provide services probably for the hospital as well as in their own practice if they wanted to.

Q. And do you have a general understanding of the ambulatory surgical center?

A. Sort of.

Q. Okay. Yeah. But do you—did you support those parts of House Bill 2?

A. I do. Yeah.

Q. And just from your experience, from what you went through, why do you think those—or at least why do you think those are important?

A. Yeah. So for me I didn't have—kind of talking to the facility, no one explained a clear path or clear plan of what to do if things went wrong. I felt like things were going wrong, so I was debating in my head, you know, do I need to—I didn't know what to do, so my only thought was, do I need to call 9-1-1 or do I need to go to the emergency room? What do I

need to do? I obviously didn't want people to know, so that was what stopped me from doing it.

But, you know, kind of looking at the bill, I could see how, had I been in a center, I may have had people who were [99] familiar with the procedure, that I could have asked questions and said, Hey, is this normal? It was terrifying at the time. And so to have that ability to know that, if something was going wrong—you know, I don't know how close I was or not to things going wrong. But if something was going wrong, to have emergency services available, I think that would have been extremely helpful.

Q. And, again, in your opinion, as someone who has had an abortion, do you believe the State should be doing more to regulate abortion providers or would you be in favor of less regulation?

A. More regulations.

Q. And why is that?

A. My own experience was that there was a lack of informed consent and a lack of continuum of care that was kind of through that process. I didn't feel like I was properly introduced to the doctor. I didn't feel like I had a good understanding of what was going to happen. So then it's obviously terrifying when things that you weren't expecting start happening. And I wasn't sure who to contact if something went wrong or where to go.

MS. KLUSMANN: All right. No further questions. Pass the witness.

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[100] **CROSS-EXAMINATION**

BY MS. SOIFER:

Q. Good afternoon, Ms. Jimenez. As you know, I'm Jan Soifer, and I'm one of the lawyers representing the plaintiffs in this lawsuit. And we met once before when you came to my office to have your deposition taken on July 22nd; isn't that right?

A. Yes.

Q. And you had a lawyer with you at that deposition, didn't you?

A. I did not.

Q. Mr. Michael Norton with the Alliance Defending Freedom from Greenwood Village, Colorado, wasn't he present?

A. Not to my knowledge.

Q. Is he here today?

A. I don't know who that is.

Q. You don't know who that is?

A. No.

Q. And so if the deposition transcript shows that he was present, that wasn't somebody that you knew?

A. No.

Q. And it wasn't somebody that you got any legal advice from?

A. No.

Q. All right. You also had—you did have two other people with you, though; isn't that right?

A. Yes.

[101] Q. And that was Joe Pojman, the executive director for Texas Alliance for Life, and Terry Williams, also from that organization?

A. Yes.

Q. And this is an antiabortion group you've worked with, isn't it?

A. I believe that's one of things they stand for, yes.

Q. And you've done speaking engagements for this group, haven't you?

A. I have. One.

Q. Including at an event called Texas Rally for Life, at which you were paid for your speech?

A. Yes.

Q. In fact, it's fair to say that you are an antiabortion activist, isn't it?

A. I wouldn't say that.

Q. Well, Terry Williams with the Texas Alliance for Life, is she here today?

A. She's not.

Q. She contacted the Texas Attorney's General's Office and suggested that they contact you; is that right?

MS. KLUSMANN: Objection, Your Honor. That's hearsay.

THE COURT: Well, the way you phrased the question would call for hearsay. Ask her what her personal knowledge is [102] about it.

MS. SOIFER: All right.

Q. (BY MS. SOIFER) Ms. Jimenez, do you know how it is the Texas Attorney General's Office came to contact you?

A. Yes.

Q. And how was that?

A. I believe they spoke to Terry and asked if they knew anyone who had any experiences with abortion.

Q. All right. And you had before your deposition at least three conversations with Andrew Stephens from the Texas Attorney General's Office before your deposition; is that right?

A. I believe so, yes.

Q. And he asked you if you'd testify at this trial?

A. Yes.

Q. And the only discussions that you had with him were that you were going to tell your own personal story; is that right?

A. Correct.

Q. And by "your story," you mean what it is you've talked about here today, your personal experiences from 2004?

A. Right.

Q. And that was, to be clear, a medication abortion 10 years ago at the Planned Parenthood Clinic in Waco?

A. Yes.

Q. And you don't know if that was an ambulatory surgical [103] center, do you?

A. I do not.

Q. In fact, you don't really now what an ambulatory surgical center is, do you?

A. Not by the definition in the bill.

Q. All right. And you don't know whether or not the doctor who prescribed the medication for you had admitting privileges at a local hospital, do you?

A. I do not.

Q. And you don't know what the admitting privilege requirements were under Texas law prior to HB 2, do you?

A. I'm sorry. Ask the question again.

Q. Yes. You don't know what the admitting privileges requirements were prior to HB 2 in Texas, do you?

A. Right. No.

Q. And you don't know what requirements a doctor must satisfy in order to obtain admitting privileges at a hospital, do you?

A. No.

Q. And you ultimately didn't have any complications that require that you get emergency medical care or that you go to a hospital, did you?

A. Right. I debated it. And so I think—I mean, I was right on the line. I could have gone, and that would have played out how it played out. But I did not go.

Q. And when you went to that Planned Parenthood and had that [104] initial appointment, they gave you some paperwork, didn't they?

A. I believe they did.

Q. And you don't remember what was in that paperwork, do you?

A. I do not remember.

Q. So you don't know whether or not there were instructions in there on what you should do if—if you should have any complications?

A. Correct. I do know it wasn't verbally explained to me at any point.

Q. All right. And you don't know if there was a phone number in there given to you about where to call if you had any questions?

A. Correct.

Q. And you don't know where that paperwork is now or if you even have it?

A. It's been 10 years.

Q. All right. So, in any event, as far as you know, HB 2 doesn't include any additional provisions for information to be given prior to an abortion?

A. Sorry. Ask the question again.

Q. Yeah. HB 2 doesn't include any additional provisions for paperwork to be given or instructions to be given or requirements to meet informed consent?

A. Correct.

Q. And back then you were starting college, and now you are a [105] counselor; is that right?

A. Yes.

Q. And you've worked for a pregnancy resource center, Care Net. And, in fact, you still volunteer there?

A. Yes.

Q. A pregnancy resource center is a facility that opposes abortions and counsels women against abortions; isn't that correct?

A. No.

Q. Well, it offers women alternatives to abortions; is that correct?

A. It goes through all of their options with them, yes.

Q. And you support the admitting privileges and ambulatory surgical requirements at issue in this lawsuit because you wish abortions were less within reach, because that may have slowed you down in your decision-making process. Isn't that true?

A. That would—I think that was mentioned as part of my personal, you know, story. But that isn't necessarily why I feel like—I kind of explained earlier why I felt like it was important, in general, for women.

Q. Well, you remember when you had your deposition taken back on July 22nd?

A. Right.

Q. And you remember that you were under oath?

A. Right.

[106] Q. And have you—and you had—you knew—you did your best to answer the questions truthfully and completely, didn't you?

A. I did.

Q. And have you had an opportunity to review the transcript of your deposition?

A. I had an opportunity last night.

Q. All right. And it's—it's about 60 pages long. Did you read it?

A. I read the whole thing.

Q. And did you provide anybody with any corrections or changes to your deposition transcript?

A. I was never informed that was an option.

Q. All right. So let me show you a copy of your deposition.

If you will turn to page 32, please.

A. (Complies)

Q. All right. So on page 32, you see where the question was asked if you understand that it's these two requirements; that is, the admitting privilege requirement and the ambulatory surgical requirement, that are at issue in this case.

Do you see that?

A. Yes.

Q. And I—and the question was:

"QUESTION: Do you support the imposition of these two requirements on abortion providers?"

[107] Do you see that?

A. Right.

Q. And you said yes?

A. Uh-huh. So from just my personal experience.

Q. Right. And the answer was: "For me there was a lot that happened that I didn't know was going to happen medically during the procedure. There was a point where I felt like I could definitely die or pass out or somebody was going to find me in a bathroom with a bunch of blood. So to me I would have felt better knowing that I had as an option—I think that would have—that would have been a good thing. I think, you know, I understand that may mean there would be less—or less within reach. I wish there was less within reach because it might have slowed me down a bit in my decision-making."

Was that your answer?

A. Yes.

Q. So in your deposition when we—when you were asked why it was you supported this law, it was in the hopes that it would slow you down in your decision-making, if you had had those two requirements imposed?

A. I mean, there's more in there than just that. But say definitely the first part, which I kind of talked about earlier. And then, again, you know, those were questions I was just kind of answering—I was answering them to the best of my knowledge, but I'm not an expert. I'm here to tell my story [108] and just how it affected me personally. So I'm not claiming to be an expert on the bill or these—you know, these—

Q. But that was your answer at the deposition, correct?

A. Sure. Yeah.

Q. If you had—if in fact these requirements had been in place and the abortion clinic in Waco had been shut down in the year 2004 and if you had had to come to Austin to have a medication abortion, and then you had returned to your dorm room in Waco, your doctor having admitting privileges within 30 miles of the facility in Austin would haven't made you safer, would it?

A. But I would have taken personal responsibility for that. I mean, if I shared that with you guys and I was sent—or shared it with Planned Parenthood and was sent on my way and they explained to me that that was a risk, then I would

absolutely take personal responsibility for choosing to go further away than what the doctor could provide admitting privileges for.

Q. You don't know what it takes to get admitting privileges, do you?

A. No.

Q. And you don't know the difference between clinics and ambulatory surgery centers?

A. I think the most I know is it would provide more emergency type of services.

[109] Q. All right. But you testified in your deposition that you do not know the difference; is that correct?

A. Right.

Q. And you—but you do know that it would be difficult for abortion providers to meet the ambulatory surgery center requirements, don't you?

A. I think you guys have made that clear, yes.

Q. Well, isn't that the answer you gave in your deposition?

A. Yes.

Q. And that is why you support them, right?

A. Can you ask the question again?

Q. Yes. Because it would be more difficult for abortion providers to meet the ambulatory surgery center requirements, that is why you support them?

A. That's one component of, like, a three-part answer.

Q. You haven't done any analysis of abortion complication rates in ambulatory surgical centers, have you?

A. No.

Q. And you haven't done any analysis of abortion complication rates in clinic settings, have you?

A. No.

Q. And you can't identify any data or research indicating ambulatory surgical centers are safer than clinics, can you?

A. No.

Q. And you don't know if the ambulatory surgical center [110] requirements apply to doctors performing surgical abortions, medical abortions, or both, do you?

A. No.

Q. And you don't have any personal knowledge about how Whole Woman's Health in McAllen operated, do you?

A. No.

MS. KLUSMANN: Your Honor, I'm going to object. She's already testified several times she's not an expert in admitting privileges or ambulatory surgical centers.

THE COURT: No. She's asking her about her personal knowledge of how these things operate, and I'm going to allow complete cross-examination of the witness. So the objection is overruled. You may proceed, Ms. Soifer.

Q. (BY MS. SOIFER) And you don't have any personal knowledge about Dr. Sherwood Lynn or any of his practices, do you?

A. No.

Q. And you don't have any personal knowledge of Austin Woman's Health Center or their practices, do you?

A. No.

Q. And you don't have any personal knowledge of the Killeen Woman's Health Center or their practices, do you?

A. No.

Q. And you don't have any personal knowledge of Dr. Lamar Robinson or his practices, do you?

A. No.

[111] Q. Is the same also true for Dr. Lendol Davis? Do you have any personal knowledge of him or his practices?

A. No.

Q. And you don't have any personal knowledge of the practices of Reproductive Services of El Paso?

A. No.

Q. And is that also true for Dr. Pamela Richter?

A. Correct. Yes.

Q. So the experiences that you had at Planned Parenthood in Waco, you don't have any personal knowledge of whether other women had the same or similar experiences at any of the plaintiff abortion providers in this case, do you?

A. No.

MS. SOIFER: Pass the witness.

THE COURT: Ms. Klusmann?

MS. KLUSMANN: No further questions, Your Honor.

THE COURT: You may step down.

They're all abandoning you, Mr. Stephens.

MR. STEPHENS: I thought that would happen.

Your Honor, the State calls Todd Giberson.

(Witness sworn)

****

[112] **TODD GIBERSON,**

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. STEPHENS:

Q. Good afternoon, Mr. Giberson.

Mr. Giberson, to your right there's a binder that contains at the last tab a document entitle Direct Testimony of Todd Giberson. Could you have—could you turn to that and review that document.

A. In this binder here.

Q. It should be that binder, but I'll check.

A. Okay.

Q. It's actually at tab 3. Do you see that Direct Testimony of Todd Giberson now?

A. Yes. This is my direct testimony that I submitted.

Q. Okay. If you could have—take a moment to review that and make sure you're familiar with what's written there.

A. Okay. This looks like—yes. This is the report I submitted.

Q. Okay. Mr. Giberson, is that a true and accurate statement of the testimony you're prepared to give today in this case?

A. Yes.

MR. STEPHENS: Your Honor, we would offer the written direct testimony of Todd Giberson as the direct testimony of Mr. Giberson in this case.

[113] MS. BHANDARI: No objection, Your Honor.

THE COURT: All right. The declaration entitled Direct Testimony of Todd Giberson is admitted.

MR. STEPHENS: And we pass the witness, Your Honor.

CROSS-EXAMINATION

BY MS. BHANDARI:

Q. Good afternoon, Mr. Giberson.

A. Hi.

Q. Your testimony in this case is solely about the geographical distribution of women of reproductive age in Texas; is that correct?

A. Yes.

Q. You don't offer any testimony about whether or not any woman or group of women in Texas face

substantial obstacles in accessing abortion services at the current time, do you?

A. Only within the confines of the exercise that I did geographically, yes.

Q. And that exercise being, you calculated the distances of women of reproductive age from certain provider facilities in Texas; is that correct?

A. Yes.

Q. You're not a lawyer, are you?

A. No, I am not.

Q. So in your testimony, when you refer to any determinations by the 5th Circuit Court of Appeals regarding what constitutes [114] a substantial obstacle, you are simply stating what you have been told by the State's attorneys; is that correct?

A. That is correct.

Q. And so that applies to any testimony you offer regarding the significance of the 150-mile distance from provider facilities; is that correct?

A. Yes. The 150 miles number was a number provided to me, not something that I came up with.

Q. And that was provided to you by the State's attorneys?

A. Yes.

Q. And is the same true for the three-hour travel time distance analysis that you conducted? That three hours was provided to you by the State's attorneys?

A. That is correct.

Q. So you had no independent reason for choosing a 150-mile or a three-hour travel time analysis; is that correct?

A. That's correct.

Q. In calculating the three-hour travel time to any given facility, did you assume that a woman had access to a car?

A. Travel time and distances was assuming normal road travel, yes.

Q. Did you assume that a woman would be driving at the speed limit posted on the highways or roads that she would have to travel on?

A. When those speed limits are factored into travel times, [115] yes. They assume speed limits—posted speed limits.

Q. Okay. So if a woman relies on public transportation or does not have access to a car, then her inclusion in your analysis within a three-hour travel time would be incorrect; is that right?

A. I think public transportation, buses, for example, travel the speed limits between cities as well. I don't see that that's a factor.

Q. So it would depend on traveling at the speed limit to reach a three-hour travel time; is that right?

A. A three-hour travel time? I'm sorry. Maybe I'm not understanding the question.

Q. I just wanted to understand that the three-hour travel time assumes travel at the speed limit on the highways?

A. That is correct.

Q. Okay. Could you please turn to page 4 of your direct testimony.

A. (Complies)

Q. You list 10 abortion provider facility addresses here; is that correct?

A. Yes.

Q. And these addresses were provided to you by the State's attorneys; is that correct?

A. That is correct.

Q. Okay. And the first six addresses on this page are for [116] provider—abortion provider facilities that will meet the ASC requirement on September 1st; is that correct?

A. That is my understanding, yes.

Q. Okay. So could you look at page 11 of your direct testimony, please.

A. (Complies)

Q. So the first six addresses on page 4 of your direct testimony, in these two tables, they correspond to the six ASC facilities that you have identified in the tables; is that correct?

A. That's correct. The areas marked "number one."

Q. Okay. And the addresses—the addresses for the first six provider facilities are respectively: Houston, Austin, Dallas, Houston, San Antonio, and Fort Worth; is that correct?

A. That's correct.

Q. And does this list of six cities that contain ASCs that will be providing abortions—able to provide abortions on September 1st, does that correspond to the metropolitan areas that Dr. Grossman included in his testimony when he analyzed the distance women would be from a provider facility on September 1st?

A. He calculated county to county. He said a county that—in his report, a county that had in it an abortion provider, and so he just said county to county.

Q. Right. I'm asking, Dr. Grossman, when he looked at the [117] distances women would be on September 1st, he looked at the same metropolitan areas that correspond to these first six facilities?

A. Yes. He looked at those areas as part of his analysis.

Q. Okay. Can you look at the address number seven that you listed on page 4.

A. Yes.

Q. Which city and state is this abortion provider located in?

A. That is Santa Teresa, New Mexico.

Q. So that is a facility outside of Texas?

A. It would be outside Texas.

Q. And you included this address at the direction of the State's attorneys; is that correct?

A. That is correct.

Q. Do you know whether this abortion provider facility in New Mexico meets the requirement for admitting privileges as defined in Texas law?

A. I don't myself, no.

Q. And do you know whether this provider in New Mexico meets ambulatory surgical center requirement as defined in Texas law?

A. I do not myself.

Q. Okay. At this moment I'd like to talk about the actual number you calculated. If you could please turn to page 11.

A. (Complies)

Q. This is page 11 of your direct testimony. Can you [118] describe what this page contains?

A. Well, the—the areas that are listed zero through five in the first table and zero through eight on the second table represent a summation of statistics or population numbers within areas that—of the State that I had defined geographically.

Q. Okay. So is it fair to say that this page shows two tables that contain your calculations for the number of Texas women of reproductive age who live within 150 miles of certain provider facilities, and then the bottom table is within 150 miles or a three-hour travel time of certain provider facilities?

A. Yes.

Q. Okay. So I'd like to look at first table, top of the page. How many women—total women of reproductive age do you calculate there to be in Texas?

A. Total women of reproductive age, 5,326,162.

Q. Okay. And then looking at the line for the six ASC facilities, how many women of reproductive age in Texas do you list as living within 150 miles of those six facilities?

A. Number five, you say, the Lubbock facility?

Q. No. Sorry. Number one. The six ASC facilities.

A. Okay. 4,434,274.

Q. So if we subtract the number that you just said from the total number of women of reproductive age in Texas, which is [119] 5,326,162, the number we get is 891,888 women; is that correct?

A. I could calculate that out, but you're saying that—are you providing a number?

Q. If I subtract the number 5,326,162—sorry. If I take that number and subtract from it 4,434,274 women, that amounts to 891,888 women.

A. Something in that range, yes. I would go along with that.

Q. So according to your calculations, that is the number of Texas women of reproductive age who will live outside the 150-mile range of one of those six ASC facilities?

A. That is correct.

Q. And then a similar question for table—the second table. If we include the three-hour drive time and look at the number you have for the six ASC facilities, that is 4,434,291 women; is that correct?

A. Correct.

Q. And if I subtract that from the total number of women of reproductive age in Texas that you've listed in that table, I get a number of 891,871 women.

A. It would be about that, yes.

Q. Okay. So according to your opinion, there will be over 891,000 women of reproductive age in Texas who will live either outside a 150-mile distance from a provider facility on September 1st or a three-hour drive time; is that correct?

A. Yes.

[120] Q. Okay. And then you have a figure in the top table listed for the McAllen facility, line three. Do you see that?

A. Yes.

Q. And that says 332,637; is that correct?

A. Correct.

Q. So does that figure represent the number of women of reproductive age who would have been within 150 miles of a provider facility if the McAllen clinic were open?

A. Yes. Again, I'm not myself familiar with what's going to be open or closed, except what was presented to me. But I understand that the closure of McAllen would mean—would affect that many women, yes.

Q. Okay. So those are the women who now live outside of a 150-mile distance from a provider; is that correct?

A. Assuming the closure of that facility, yes.

Q. Okay. And you used 2010 U.S. census data for your numbers in this testimony; is that correct?

A. That is correct.

Q. And is it fair to say that the number—the population of Texas has increased since 2010?

A. The population of Texas is growing all the time, yes.

Q. So, most likely, the figures represented here of reproductive age women are actually likely higher; is that correct?

A. At any given time it's probably higher than the stated [121] number, yes. If you looked at the raw numbers, that is.

Q. In your direct testimony you refer a few times to various percentages of women who live outside a 150-mile range or a three-hour drive time for reasons unrelated to the Act; is that correct?

A. Yes. That's what I put in my report or my testimony.

Q. Yes. But your only basis for that statement is what the State's attorneys told you; is that correct?

A. That's correct.

Q. You testified at your deposition that the Rio Grande Valley is the site of many *colonias*; is that correct?

A. It is.

Q. And you testified that the *colonias* in the Rio Grande Valley often lack basic infrastructure; is that correct?

A. That's correct.

Q. And with that infrastructure include things such as transportation?

A. Some of them lack paved roads, yes. But mostly it's water or wastewater services.

MS. BHANDARI: Okay. Thank you. No further questions.

REDIRECT EXAMINATION

BY MR. STEPHENS:

Q. Mr. Giberson, Plaintiffs' counsel just asked you a question with respect to the second table presented in your [122] direct testimony. Is this the second table as you understand it?

A. Yes, it is.

Q. And I believe the question you were asked is whether, if you subtracted 4,434,291 from 5,326,162, that the number that you would get from doing that subtraction, whether that is the number of women who would live outside of 150-mile road distance or a three-hour drive from a provider facility listed in area one. Do you recall that question?

A. Yes.

Q. And I believe you said that sounded accurate?

A. It would be something less than 1 million, yes.

Q. Okay. And your answer, did that take into account the three-hour road distance from Laredo, Abilene, or Texarkana listed in six, seven, or eight above?

A. No. That calculation would not have factored in those areas, no.

Q. So, in fact, you can't just subtract 4,434,291 from 5,326,162 to get the number of women who would live outside of that distance; is that right?

A. If you factor drive time, then you'll have to include those areas.

Q. Right. If you factor drive time, there are actually more women who live within the three-hour distance; is that right?

A. Yes.

[123] Q. Okay. Could you describe your work experience for the Court?

A. I'm a geographer by degree, and I've worked in matters geographic in computer programming, application programming, all types of programming involving census data and geography for nearly 25 years.

Q. Okay. And I would like to walk through the analysis you did in reaching the numbers you did in tables one and two of your direct testimony. And I'd like to start with a map that is included in your direct testimony. Is this a map that you created?

A. Yes, it is.

Q. Could you describe what is shown by the outline of area one on this map?

A. What I did was there has been discussion of the 150-mile travel distance. I began with a network—a road network, the major roads that cover the State of Texas, and included points to indicate where the actual facility—for example, addresses one through six, where they were, there was a need created for those facilities. And from that point I generated travel distances outward from each of those six independently. But then I combined the results into one large area which I numbered "number one." That represents where traveling along the roads you could reach 150 mile—reach out to 150 miles.

Q. Okay. So the outline in red around the "number one" [124] depicts the border of the 150-mile distance from the six ASC providers, as you understand it?

A. Yes. And that—just to clarify, that's within—within the State. If you look out in El Paso, for example, you know, you could travel into New Mexico. But I wasn't factoring in—or Oklahoma. I just clipped the

line there. What's critical is where the line crosses within the State.

Q. Within the State of Texas?

A. Yes.

Q. Okay. So what—why is the line on the border of area one not a straight, curved line?

A. Well, I did not use a "crow flies" distance. That would have made a circular area around the facility. When you travel along the roads, you can't necessarily reach every point. It depends on where the roads are.

Q. Okay. So, for example, towards the middle of the left side of the line, it moves out to the left. Why is that?

A. Well, if you can travel along a highway, you can reach, for example, Eagle Pass in Maverick County there. But if you—and then along the—along I-10, you can move out a little farther. But in the more rural areas, like Real County—

Q. That's I-10?

A. Yes.

Q. Okay.

[125] A. —you can't get there. Because of the road availability, you can't travel as easily outward that way.

Q. Okay. So once you had created the area that you identified as area one, what did you do next with respect to the calculations that you presented in the tables?

A. Well, my approach was to—after I had delineated that area, I overlaid that on the census blocks of the State of Texas. There are over 900,0000 blocks—census blocks that cover the State. So I overlaid that area I had defined and assigned all of those blocks a "number one," for example, for that area or another number for the other areas I generated.

Q. Okay. And what's a census block?

A. A census block is—well, you would say like a city block is a census block. It's usually bounded by a physical feature. It's generated and produced by the U.S. Census Bureau primarily for redistricting purposes, but it's useful in other applications as well. But it's a block that's bounded by roads usually on every side.

Q. Okay. And is the—I was planning on showing those together, but it's not going to work. So this is the table that you prepared, table one; is that right?

A. Yes.

Q. And in this table what's listed as area one, what do the three columns to the right describe?

A. The first column is just the total population that we [126] summed up in that area. That would include men, children. That's the total census population. The middle column is just as it says, females age 15 to 44. That number again comes directly from the Census Bureau and is released at a block level—census block level. And I sum up the numbers for that area. And then the final column is just a percent of that area relative to the other areas of the State.

Q. Okay. So—so the second column that has 4,434,274 females age 15 to 44, that is with respect to area one—residing in a census block located in area one of your first map?

A. Yes. And just to clarify, if the—if the line I drew split the census block, I would include the census block if it was more than 50 percent in or exclude it if it was 50 percent or more out.

Q. Okay. And then the percentage that you calculate in the third column is a percentage of what?

A. That would be—for example, that 83.3 percent number would be the percent of females in that age range in the—in the whole State of Texas.

Q. Okay. So 83.3 percent of females age 15 to 44 reside in a census block located in area one; is that right?

A. Yes.

Q. And area one, as you described, is the area that depicts the 150-mile road distance from an

existing ambulatory surgical [127] center as you understand those addresses that we provided to you?

A. Yes.

Q. Okay. And moving to area two, what does area two as far as the outline show?

A. Okay. Area two was—again, I was provided another address. That was the Santa Teresa, New Mexico address. There's a facility there, and I looked—I looked it up. It's three-fourths of a mile from the border—the New Mexico-Texas border. And it has access along the road directly—along the road into El Paso. So I generate—I use that facility in New Mexico and generated a 150-mile travel distance outward from it and it extends into Hudspeth and into Culberson County.

Q. Okay. And that's what's shown on the—on the line that extends to the east of El Paso and depicted as area two on the map; is that right?

A. Yes.

Q. And what about the area depicted as area four?

A. I was given another address for a facility in El Paso and within the City of El Paso itself. So, of course, it was slightly more to the east than the New Mexico facility. But I generated from it also the same 150-mile travel distance. And so it extended a little farther to the east, as you see. But as I stated in my testimony, I gave a preference to the facility—the

facility in New Mexico because I was given to [128] understand—I was given that that would remain open.

Q. Okay. And how many women live age 15 to 44, if you recall, lived in that area four?

A. I think it was like six or something, yeah. Women of that age, I show six in that little sliver that would be within 150 miles of the El Paso location but not within 150 miles of the New Mexico location.

Q. And how many people total live in that area four?

A. I show 45.

Q. So it's a fairly sparsely populated area of the State?

A. Sparsely populated.

Q. Okay. Moving to the south, to area three. What is—how did you calculate the boundaries of area three?

A. I was provided an address in McAllen, and I performed the same exercise. I used the road network to tell me how far out I could go, 150 miles, and I drew my line there. And you can see at the top there's some overlap in Jim Wells County and particularly in Duval that is—area one is given preference. But they would overlap slightly there.

Q. And when you say given preference over—over another area, you just mean that—what do you mean by that?

A. Well, for reporting purposes, that would mean that that area, for example, down to—in the Alice area and south of Alice in Jim Wells County, that that area would be within the 150-mile driving distance of the San Antonio facility. So I [129] included it in area one.

Q. I see. And area five, what did you depict with the outlines of area five?

A. I was given an address for a facility in Lubbock. And I performed the same exercise there, extending outward, and generated that boundary that you see which includes Amarillo and Odessa-Midland areas.

Q. Okay. After you prepared this map, you also prepared a second map; is that right?

A. That's correct.

Q. Is this the second map you prepared?

A. Yes, it is.

Q. How does that map differ from the first map that we just looked at?

A. Well, you'll notice some—there's some additional areas numbered six, seven, and eight, the Laredo area, the Abilene area and Texarkana area. So

there are some areas that I added and generated individual numbers—tallies for.

Q. Okay. And why did you add those areas around Laredo, Abilene, and Texarkana?

A. As was mentioned, I was also—besides the 150-mile road distance I was given, I was to look at the three-hour drive time. Now, for me to do that, I would have to have speed limits on my—in my data, which I did not.

What I did was I looked for areas that were near the [130] 150-mile line that were along—in this case what I decided to use were along interstates because I was—because I knew you could travel faster than an average of 50 miles an hour along the interstates. So I found areas that were close, that were along interstates, and went to an Online service to determine whether points on the edges—the far edges of those urban areas were shown to be within three hours drive time. And I made a determination that those cities were in their entirety. And so I came up with a method to describe—to show them being included in a three-hour drive time on this map.

Q. So, for example, in area six on the—which encompasses Laredo; is that right?

A. Yes.

Q. You could drive I-35 to San Antonio in three hours based on the speed limits and your estimates that—which you calculated; is that right?

A. Yes. It showed you could actually drive beyond the City of Laredo within three hours.

Q. Okay. And with respect to area seven, you could drive from west of Abilene on I-20 to the location you were provided for an ASC in Fort Worth; is that right?

A. Yes.

Q. And from Texarkana you could drive west on I-30 to Dallas within three hours; is that right?

A. That's correct.

[131] Q. Okay. And is this the second table that you prepared for purposes of your testimony today?

A. Yes.

Q. And so where on this table are those three-hour distances shown?

A. Those are areas marked six, seven, and eight, and those are the numbers tallied—summed up for those areas.

Q. Okay. So when I asked you the question earlier about the number of women age 15 to 44 who reside within three hours but not 150 miles, that would be 56,379 for area six; is that right?

A. Well, the number—the number of women in area six?

Q. Right.

A. 56,379? Yes.

Q. And for area seven, what was that number?

A. 17,447

Q. And area eight?

A. 16,142.

Q. And so those are additional women who live within three hours of the clinic in one of the six existing ASCs, but not within 150 miles?

A. That's correct. And, again, I only looked at specific areas. I could have—I would say that would be conservative because you could go—you'll see, like, Del Rio is very close. Marshall is kind of split along I-20 to the east. [132] There are some areas—other areas that were close, but I didn't—I didn't really look at those because they weren't along interstates. But they very well might—if you did an exhaustive analysis, you might even pick up some other areas like that.

Q. For example, you mentioned Del Rio, and Del Rio is here; is that right?

A. Yes.

Q. So if you took Highway 90 east from Del Rio, you could be within three hours of the location of the ASC in San Antonio; is that right?

A. It's possible you could reach that area within three hours.

Q. So is it fair to say there could be more women within the three-hour distance than are depicted by the lines shown as area one?

A. Yes.

Q. Okay.

THE COURT: At this time we're going to take our evening recess. We'll be in recess until 9 o'clock in the morning. I urge you-all to spend your time trying to do some preparation. I would like to finish this by 5:00 tomorrow, if at all possible. So at this time the Court will be in recess.

(End of transcript)

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS (AUSTIN)

(Admitted Aug. 6, 2014)

EXHIBIT
P-211
1:14-CV-284-LY

From: Vincent M. Rue <vincerue@bellsouth.net>
Sent: Sunday, June 29, 2014 7:03 PM
To: Mayra Thompson MD (drmayra@sbcglobal.net)
Subject: additional expert report to review
Attachments: Grossman Expert Report 6-16-14.pdf

Mayra—

I forgot to send this report to you as well. I am still drafting and will keep you posted.

Vince

[LOGO]
Vincent M. Rue, Ph.D.
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3030 Hartley Road, Suite 220
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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS (AUSTIN)

(Admitted Aug. 6, 2014)

EXHIBIT
P-212
1:14-CV-284-LY

From: Vincent M. Rue <vincerue@bellsouth.net>
Sent: Sunday, June 29, 2014 9:41 PM
To: 'Mayra J. Thompson, M.D.'
Subject: RE: additional expert report to review

No, just wanted you to review. I don't know when you arv Dallas, but I will keep working on your report and send to you in the middle of the night so perhaps you could review in the morning? Thanks for you patience and kind assistance.

Vince

From: Mayra J. Thompson, M.D.
[mailto: drmayra@sbcglobal.net]
Sent: Sunday, June 29, 2014 9:12 PM
To: Vincent M. Rue
Subject: Re: additional expert report to review

I will review on the plane since I have saved it to my computer. do you want me to add more comments after I review his statement, or shall I just save it for future reference.

On Sunday, June 29, 2014 8:04 PM, Vincent M. Rue <vincerue@bellsouth.net> wrote:

All reports must be submitted tomorrow. Our deadline is to get this done by tonight so the TX Attorney General team can review prior to submission tomorrow. Six rebuttal reports will be submitted.

From: Mayra J. Thompson, M.D.
[mailto: drmayra@sbcglobal.net]
Sent: Sunday, June 29, 2014 8:21 PM
To: Vincent M. Rue
Subject: Re: additional expert report to review

When is the final due? I thought it was today.

Sent from my iPhone

On Jun 29, 2014, at 19:02, "Vincent M. Rue" <vincerue@bellsouth.net> wrote:

> Mayra—
>
> I forgot to send this report to you as well. I am still drafting and will keep you posted.
>
> Vince
>
> <image001.jpg>
>
> **Vincent M. Rue, Ph.D.**
> *Litigation Consulting & Research*
> 3030 Hartley Road, Suite 220
> Jacksonville, FL 32257
> Voice: 904.342.0352
> Fax: 904.342.0353
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<Grossman Expert Report 6-16-14.pdf>

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS (AUSTIN)

(Admitted Aug. 6, 2014)

EXHIBIT
P-213
1:14-CV-284-LY

From: Vincent M. Rue <vincerue@bellsouth.net>
Sent: Monday, June 30, 2014 4:21 AM
To: Mayra Thompson MD (drmayra@sbcglobal.net)
Subject: Draft of your rebuttal report
Attachments: Thompson Rebuttal Report.docx

Mayra—

I tried to use as much of your material as I could. Time ran out and this is the best I could do. Please review and use "track changes" in Word so I can easily see your changes.

Please let me know what your schedule is for tomorrow as there will likely be changes in your report suggested by the TX AG's team as well and I will need to run those by you.

Also, when you get into the office today, could you please sign your name on a blank piece of paper and have your assistant scan and email that to me? Alternatively, she could fax it to me at 904.342.0353.

Many thanks.

Vince

[LOGO]
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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS (AUSTIN)

(Admitted Aug. 6, 2014)

EXHIBIT
P-214
1:14-CV-284-LY

From:	Vincent M. Rue <vincerue@bellsouth.net>
Sent:	Thursday, July 10, 2014 7:09 PM
To:	Mayra Thompson MD (drmayra@sbcglobal.net)
Subject:	articles to review
Attachments:	Thorp, Hartman & Shadigian (2005) Long term physical & psychological health consequences of abortion.pdf; Thorp (2012) Public Health Impact of Legal TOP.pdf; Coleman (2011) BJP Meta-Analysis of abortion & mental health.pdf; Calhoun et al. (2007) PTB and Abortion J Repro Med 10-2007.pdf; Huang et al (2014) Meta-analysis of induced ab & breast cancer.pdf

[LOGO]
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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS (AUSTIN)

(Admitted Aug. 6, 2014)

PLAINTIFFS
EXHIBIT
218
A14CV284LY

From: Vincent M. Rue <vincerue@bellsouth.net>
Sent: Friday, June 06, 2014 5:26 PM
To: 'Deborah Kitz'
Subject: RE: bullet point draft

Thank you very much Debbie. On time delivery to boot! Will review and give you a call.

Thanks again.

Vince

From: Deborah Kitz
[mailto:dkitz@brosharconsulting.com]
Sent: Friday, June 06, 2014 3:21 PM
To: Vincent Rue
Subject: bullet point draft

Vince – attached please find a bullet point type draft of my report. Let me know your thoughts, concerns, etc. Of course, if you decide to move forward with this or a version thereof, I will provide the necessary reference materials. THanks.

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS (AUSTIN)

(Admitted Aug. 6, 2014)

PLAINTIFF'S
EXHIBIT
220
A14CV284LY

From: vincerue <vincerue@bellsouth.net>
Sent: Tuesday, August 05, 2014 11:03 PM
To: Blacklock, Jimmy
Subject: Fw: Next version
Attachments: Report-2.docx

Vincent M. Rue, Ph.D.
Consulting, Counseling & Research
RUE & STANFORD-RUE, P.A.
[redacted]

------ Forwarded Message ------

From: Deborah Kitz <dkitz@brosharconsulting.com>
To: Vincent Rue <vincerue@bellsouth.net>
Sent: Saturday, June 7, 2014 2:08 PM
Subject: Next version

Vince – here's another draft. I removed my original comments. The comments contained herein address the questions/suggestions you made. Thanks for the input.

Deborah S. Kitz, Ph.D.
Principal, Broshar Consulting
Expert Solutions For Your Health Care Challenges
[redacted]

DRAFT

Report to the Office of the Attorney General of the State of Texas

In the Matter of:

Whole Woman's Health et al vs. David Lakey, MD et al

Submitted by:

Deborah S. Kitz, Ph.D.

Requested Opinion: Is it financially feasible for plaintiffs Whole Woman's Health, LLC and/or Nova Health Systems, Inc. d/b/a Reproductive Services to establish an ambulatory surgery center?

Documents Reviewed:

- Complaint
- Exhibits 1, 2
- Plaintiff's Amended Motion for Preliminary Injunction
- Memorandum of Law in Support of Plaintiff's Amended Motion
- Defendants' First Request for Production of Documents
- State Defendants' First Set of Interrogatories
- Nova Health Systems Profit & Loss Statements
- Whole Woman's Health Income Statements, Balance Sheets and associated documents

Background Research:

- Texas Administrative Code Chapter 135
- Texas Administrative Code Chapter 139
- Texas Department of State Health Services – miscellaneous matters including, without limitation ambulatory surgery center (ASC) listings and compilation of information reported annually by ASCs
- Texas Ambulatory Surgery Center Society
- Ambulatory Surgery Center Association

- VMG Ambulatory Surgery Center Financial & Operational Benchmarking Study 2012
- Miscellaneous documents regarding ASC development, size etc.

Findings:

Nova Health Systems

- For the 12months ending February 2014, Nova Health Systems (NHS) had a negative operating margin (both before and after "overhead expense reallocation")
- NHS's income statements include a term, 'RAPA Tfrs ' with which we are not familiar; for the period ending February 2014, this was the description for expenses of $200,638.
- For the period referenced above, NHS's income statements shows employee benefit expenses of $22,364 and payroll taxes of $21,277 Salary expenses for the same period were $52,848.

Whole Woman's Health, LLC/Whole Woman's Health of McAllen

- For 2013, Whole Woman's Health of McAllen (WWH-M) had an operating margin of 2.9% and a current ratio of 19.4. (Current ra is computed by dividing current assets by current liabilities; this ratio is considered an indicator of an entity's ability to its debts over the next 12 months.)

- In 2013, WWH-M $149,293 in management fees to Whole Woman's Health, LLC (WWH); this fee was 17% of WWH-M's total fee income. This same ratio of management fee to net income appears in the income statement for Whole Woman's Health Surgical Center, a licensed ASC in San Antonio.
- For 2013, WWH had an operating margin (profit/net revenue) of 9.1% and a current ratio of 2.38.
- In 2013, WWH received management fees of $1,617,506 from the entities for which it provides such services.
- 1188 patient visits took place at WWH-M during the period January-September 2013 (1594 annualized).
- Texas Administrative Code Chapter 135 provides specifications for (among other matters) the design and construction of ASCs; these specifications address, without limitation, operating room dimensions, HVAC, electrical systems, emergency supplies and equipment, and support services (e.g. instrument processing).
- Texas Administrative Code 139 provides specifications regarding abortion facilities. The specification address (among other matters) number of sinks, recovery space, emergency supplies and equipment, and support services (e.g. instrument processing).

Information/Opinions:

Nova Health Systems

- The limited information presented by NHS restricts the scope of the opinions that may be drawn about the financial ability of this entity to establish and ASC. In particular, neither balance sheets or patient volume information were provided.

- In my experience, employee benefit and payroll tax expenses together are about 25% of payroll in ASCs. NHS's benefit and payroll tax expenses are over 82% of salary expenses; this seems highly unusual.

Whole Woman's Health/Whole Woman's Health – McAllen

- In my experience, management fees in ASCs typically are in the range of 6%-8% of net revenue. The management fee charged by WWH is unusually high when compared to other ASCs.

- Substantial renovation would be required for a facility licensed under Chapter 139 of the Texas Administrative Code to come in to compliance with Chapter 135 of the Texas Administrative Code. Alternatively, a new location would need to be identified at which an ASC may be established. Such a location may be an existing shell or unimproved real estate. However, in my experience, establishing an ASC on unimproved real estate is more costly than fitting out an existing shell

(due to the need to construct the building shell, provide utility connections, etc.)

- In my experience, ASCs should include one operating room (OR) for every 1000-1800 cases expected to be carried out at a facility. The lower end of the range is applicable if many procedures will be of longer duration and the higher end of the range is applicable if many chases of shorter duration will be performed. The American Society of Anesthesiologist (ASA) estimates that 1000-1500 cases may be carried out in each ASC OR (*reference*).

- Based on the information above, a one OR ASC would be necessary to accommodate WWH-M's case volume.

- In my experience, a minimum of approximately 2500-30-00 square feet is necessary to accommodate a one OR ASC that must meet The Facility Guidelines Institute (FGI) requirements for design and construction of an ASC. (The FGI requirements and the requirements presented in Chapter 135 of the Texas Administrative Code are very similar.) The ASA also states that a minimum of 3000 square feet is needed to accommodate each OR (the OR itself along with support space) (*reference*).

- Based on my experience with other ASCs, fit out expenses for an existing "shell" currently are $195 per square foot or less for non-union projects. My firm currently uses $195 per square foot when preparing pro forma for "to

be established" ASCs. Based on my experience, architect and engineering (A & E) fees are about 10% of fit out expenses. Last, in my experience, building landlords typically provide a fit out allowance that, at a minimum, is equal to the per square foot rental rate multiplied by the number of square feet being rented, thereby reducing the tenant's outlay for fit out work.

- Data regarding an ASC recently established in McKinney, TX indicates that construction and A/E fees were about $302 per square foot (*reference*). Data regarding fit out for another ASC (location unknown) indicate that construction expenses were about $199 per square foot.

- To be conservative, for the purposes of the analysis necessary herein, I assumed that 3000 square foot ASC would be established at a combined construction and A/E expenses of $300 per square foot. Accordingly, the fit out of such an ASC would cost approximately $900,000.

- When preparing pro forma for multi-specialty ASCs, my firm uses $700,000 per OR to estimate the equipment expense. In this instance, "equipment expense" refers to a range of items; these include capital items such as OR lights, anesthesia machines and sterilizers; expenses for furniture (clinical and administrative); clinical instrumentation; and software and computer hardware. Others (*reference*) state that equipment expense

are about $250,000-$500,000 per OR ('equipment" is not defined). Considering that WWH-M already has much of the equipment (including certain capital items, instruments, etc.) for its current functioning, I assumed that $250,000 would be necessary to bring a new ASC in to compliance with Texas regulations.

- Based on the information above, approximately $1,150,000 in capital spending would be necessary to establish an ASC for WWH-M.

- In my experience, banks providing fit out and equipment loans require an equity contribution from ASC owners of not more than 20% of the total capital expense. Applied in this instance, lending institutions may seek an equity contribution of up to $230,000; the institutions then would provide financing for a total of $920,000 of capital expenses.

- In my experience, banks require that ASCs to which they have provided a loan maintain a current ratio of 1.0 or greater.

- For 2013, WWHY-M's current ratio was 19.4 and WWH's was 2.4, meaning that WWH has more than double the current assets with which to handle current liabilities.

- According to their web site, WWH is a privately held entity.

- In addition to establishing a new ASC, WWH/WWH-M may consider purchasing (outright) an existing facility or buying an equity

interest in an existing ASC. In my experience, depending on the particular characteristics of the existing facility (physically and financially) and whether a minority or a majority position is being purchased, purchase prices for ASC equity are approximately 4x-7x EBIDTA (earnings before interest, depreciation, taxes and amortization).

The opinions expressed above may be subject to change should additional information as originally requested and/or as may be subsequently requested, be made available for review and consideration.

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS (AUSTIN)

(Admitted Aug. 6, 2014)

PLAINTIFF'S EXHIBIT 222

From: Vincent M. Rue <vincerue@bellsouth.net>
Sent: Thursday, June 12, 2014 9:32 PM
To: 'Deborah Kitz'
Subject: RE: will it be lucky version 7

Thank you Debbie. Yes this version should do it. I accepted all changes and will incorporate references and draft into expert report format. When done, will send to you for review. Will you be around this weekend?

Thanks.

Vince

From: Deborah Kitz
[mailto:dkitz@brosharconsulting.com]
Sent: Thursday, June 12, 2014 5:34 PM
To: Vincent Rue
Subject: will it be lucky version 7

Vince--see attached report incorporating your suggestions and some other minor revisions. I am also attaching the various references. Thanks.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

Whole Woman's Health; Austin Women's Health Center; Killeen Women's Center; Nova Health Systems d/b/a Reproductive Services and Sherwood C. Lynn, Jr., M.D.; Pamela J. Richter, D.O.; and Lendol L. Davis M.D., on behalf of themselves and their patients, Plaintiffs, v. **David Lakey, M.D. and Mari Robinson,** in their official capacities, Defendants.	Civil Action No. 1:14-cv-284-LY

DIRECT TESTIMONY OF DEBORAH KITZ, Ph.D.

(Submitted Aug. 7, 2014)

1. My name is Dr. Deborah Kitz. I am a health care consultant experienced in the development and management of ambulatory surgical centers (ASC) and the Principal of Broshar Consulting, LLC in Pennsylvania Having worked with over 70 ASCs, I am intimately familiar with the administration of these facilities across the mid-Atlantic states. I was the founding executive director of one of the first

licensed ambulatory surgical centers in Pennsylvania and held this position for nine years.

2. It is my understanding that the Plaintiffs in this case oppose two provisions of Texas House Bill 2 ("the Act"), one of which requires that a physician performing or inducing an abortion have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced, and another that requires licensed abortion clinics in Texas meet minimum standards equivalent to those required under Texas law for ambulatory surgical centers.

3. It is my understanding that the basis of this lawsuit pertains to the closure of two abortion clinics, Whole Woman's Health—McAllen, and Nova Health Systems d.b.a. Reproductive Services in El Paso. My testimony addresses my opinions regarding the financial feasibility of these two providers to meet the ambulatory surgical center minimum standards required by the Act.

4. Texas Administrative Code Chapter 135 provides specifications for (among other matters) the design and construction of ASCs; these specifications address, without limitation, operating room dimensions, HVAC, electrical systems, emergency supplies and equipment, and support services (e.g., instrument processing).

5. Texas Administrative Code Chapter 139 provides specifications regarding abortion facilities. The specifications address (among other matters) the

number of sinks, recovery space, emergency supplies and equipment, and support services (e.g., instrument processing).

6. As of May 16, 2014, it is my understanding that there were 58 one operating room (OR) ASCs licensed in Texas. At least two of these one OR facilities are dedicated to carrying out abortions (Planned Parenthood for Choice ASC and Southwestern Women's Surgery Center).

7 In preparing to give this testimony, I reviewed the Reports of Dr. Anne Layne-Farrar and George Johannes filed in this case as well as their proposed written direct testimony. In her Report as well as in her direct testimony, Dr. Layne-Farrar states that the "ASC minimum standards are exhaustive." I agree that there are a number of requirements—such as certain minimum construction standards—an ASC must satisfy. As stated by Mr. Johannes in his direct testimony, "these codes are generated by councils composed of individuals with diverse expertise, including fire marshals, code enforcers, engineers, architects, business owners, healthcare professional, developers and other interested and knowledgeable experts." Mr. Johannes goes on to say that "model building codes are evidence-based" In my experience, both building codes and "operating requirements" are established by regulatory, industry and/or accrediting bodies that consider the parameters to be consistent with safe, high quality care.

8. I note that in her direct testimony, Dr. Layne-Farrar states that "[she] assume[s] that, but for the ASC requirement, there would be licensed abortion facilities operating in McAllen and El Paso as of September 1, 2014." However, it is my understanding that the Plaintiffs stated in the Complaint filed in this suit that the McAllen facility and the El Paso facility, respectively, closed due to the admitting privileges issue.

9. The limited nature of information available from Nova Health Systems (NHS) restricts the scope of the opinions that may be drawn about the financial ability of that entity to establish an ASC. In particular, neither balance sheet or patient volume information were provided to me.

10. For the 12 months ending February 2014, Nova Health Systems (NHS) had a negative operating margin (both before and after "overhead expense reallocation"). Operating margin is determined by dividing profit by net revenue. In this case:—$6854/$599,022 = -1.14%. NHS's income statements include a term, "RA PA Tfrs ," which is a term with which I am not familiar; for the period ending February 2014, this was the description for expenses of $200,638.

11. For the period referenced above, NHS's income statement shows employee benefit expenses of $22,364 and payroll taxes of $21,277. Salary expenses for the same period were $52,848. In my experience, employee benefit and payroll tax expenses together

are about 25% of payroll in ASCs. NHS's benefit and payroll tax expenses are over 82% of salary expenses; I have not previously encountered an entity with benefit expenses at this level compared to salary expenses.

12. In 2013, Whole Woman's Health—McAllen (WWH-M) paid $149,293 in management fees to Whole Woman's Health, LLC (WWH); this fee was 17% of WWH-M's total fee income. This same ratio of management fee to revenue appears in the income statement for Whole Woman's Health Surgical Center, a licensed ASC in San Antonio.

13. There were 1,188 patient visits to WWH-M during the period January 2013-September 2013 (1,584 annualized).

14. The 2013 balance sheet for WWH, LLC includes a short term liability, "HQ Due **from** WWH-M" of approximately $587,000. For the same period, the balance sheet for WWH-M includes a current asset of this sane $587,000; this is labeled "McAllen Due **from** WWH, LLC (HQ) (offset 14600)." At the risk of stating the obvious, the same monies cannot be due **from** each entity to the other.

15. According to their website (http://whole womanshealth.com/), WWH is a privately held entity, seemingly with all associated entities having common ownership. A real estate listing states that WWH-M's building is 3,006 square feet and priced at $299,000 (MLS Listing # 173892, Keller Williams Realty, available at: http://kwrgv.yourkwoffice.com/mcj/user/

FeaturePropertyDetailAction.do?lhKey.3yd-KW-4308_173892).

16. In my experience, fees charged by ASC management firms typically are in the range of 6%-8% of net revenue. The management fee charged by WWH is unusually high when compared to other ASCs with which I am familiar. In fact, the management fee charged by WWH is higher than any other management fee at any ASC with which I am familiar. If WWH's management fee were 8% of net revenue, WWH-M would have paid $70,255 to WWH in 2013 ($878,192 x 0.08). Moreover, WWH-M would have decreased their total expenses by $79,038 ($149,293—actual management fee—less $70,255), thus increasing net income to $104,759 ($25,721 + $79,038).

17 While limiting my comments to WWH-M, I agree that substantial renovation would be required for a facility such as WWH-M licensed under Chapter 139 of the Texas Administrative Code to come in to compliance with Chapter 135 of the Texas Administrative Code.

18. Generally speaking, "facility fees" may be charged to insurance carriers when covered procedures are carried out in an ASC. These same facility fees generally may not be charged when procedures are carried out in an office setting. Facility fees are distinct from fees that may be charged by a surgeon and/or an anesthesia provider. In fact, in my experience, facility fee revenue either accounts for all

or for the vastly overwhelming portion of revenue at ASCs.

19. Several approaches may be taken to establish an ASC for WWH-M. One approach is to carry out the renovations necessary to bring the existing facility in to compliance with Texas requirements for an ASC. Other approaches include identifying a new location (an existing shell or unimproved real estate) in McAllen at which an ASC may be established, entering in to a time-share arrangement with an existing ASC, or leasing a dormant or "to be closed" ASC.

20. I disagree with Mr. Johannes's assumption that two operating rooms would be needed in the ASC. In my experience, ASCs should include one operating room (OR) for every 1,000-1,800 surgical cases expected to be carried out at a facility. The lower end of the range is applicable if many procedures will be of longer duration and the higher end of the range is applicable if many cases of shorter duration will be performed. The American Society of Anesthesiologists (ASA) estimates that 1,000-1,500 surgical cases may be carried out in each ASC OR (Wajda M & Bell C. "Free-standing and Outpatient Surgery Centers." In American Society of Anesthesiologists, **2012 Operating Room Design Manual** (Chapter 15), at: https://www.asahq.org/For-MemberPractice-Management/ASA-Practice-Management-Resources/Operating-Room-Design-Manual.aspx). These estimates of operating room case volumes assume the facility is being operated during normal surgery

center business hours. It is my understanding that there currently are 58 one OR ASCs licensed in Texas, at least two of which carry out abortions, as stated earlier.

21. Based on the information above, since abortion procedures are of shorter duration, a one OR ASC would be necessary to accommodate WWH-M's case volume.

22. Mr. Johannes states in his direct testimony that 6,650 square feet would be necessary to accommodate a single OR ASC that complies with minimum standards under Texas law. He also states that approximately 7,000 square feet are necessary for a two OR facility. This is not consistent with my experience and is not supported by data regarding at least one ASC in Texas. Trinity Surgery Center in San Antonio is a 6,500 square foot facility with two ORs as well as two treatment rooms.

23. In my experience, a minimum of approximately 2,500-3,000 square feet is necessary to accommodate a one OR ASC that meets The Facility Guidelines Institute (FGI) requirements for design and construction of an ASC. (The FGI requirements and the requirements presented in Chapter 135 of the Texas Administrative Code are largely similar in substance.) The ASA also states that a minimum of 3,000 square feet is needed to accommodate each OR (the OR itself along with support space).

24. As noted above, WWH-M's existing space is 3,006 sq. ft. and, therefore, it would be adequate to accommodate a one OR ASC.

25. Based on my experience with other ASCs, fit out expenses for an existing "shell" currently are $195 per square foot or less for non-union construction projects. My firm currently uses $195 per square foot when preparing a pro forma for "to be established" ASCs that comply with the FGI Guidelines. Based on my experience, architect and engineering (A & E) fees are about 10% of fit out expenses. Lastly, in my experience, building landlords typically provide a fit out allowance that, at a minimum, is equal to the per square foot rental rate multiplied by the number of square feet being rented. This allowance reduces the tenant's outlay for the fit out work. In contrast to Mr. Johannes's estimate of $365 per square foot for new construction, data regarding an ASC recently established in McKinney, TX indicate that construction and A/E fees combined were about $302 per square foot (Reed Construction Data, "Outpatient Surgery Center Information: Outpatient Surgery Center Square Foot Cost Estimates") available at: http://www.reedconstructiondatacom/iframe/building-types/surgery-center/texas/. Data regarding fit out for another ASC (location unknown according to Design Cost Data) indicate that construction expenses were about $199 per square foot. (Design Cost Data Medical Square Foot Cost Guide) available at: http://www.dcd.com/pdf_files/0903guide.pdf.

26. Mr. Johannes provides a drawing for a two OR ASC in Figure 1 of his direct testimony. In my opinion, this drawing provides for space/rooms that exceed the requirements as presented in Texas Administrative Code 135.52(d). In particular, 135.52(d)(3) of the Texas Administrative code indicates that an exam room is discretionary but one is shown in the Figure. (The Business Manager space could serve as the private interview space). In addition, the Figure shows a total of eight (8) pre/post op stations; according to 135.52(d)(9)(B) and (10)(B), a two OR facility would only require a total of five (5) stations. Section 135.52(d)(13)(A) of the Texas Administrative Code allows for uni-sex toilets and showers. Yet, Mr. Johannes's Figure provides for separate male and female toilets and showers. Similarly, Texas Administrative Code 135.52(d)(15)(B)(i) indicates that an anesthesia workroom is discretionary; such a room is provided in the Figure. I do note that while 135.52(d)(13)(B) of the Code indicates that a lounge is discretionary, one should be included in most ASCs. In my opinion, based on the aforementioned assessment, Figure 1 does not reflect the minimum necessary for a licensed ASC in Texas and, therefore, unnecessarily inflates his statements about minimum square footage requirements and facility fit out/ construction expenses.

27 To be conservative for the purposes of the analysis herein, I assume that a 3,000 square foot ASC would be established at a combined construction and A/E expense of $300 per square foot. Accordingly,

the fit out for such an ASC would cost approximately $900,000. If WWH elected to lease space for an ASC at a presumed rental rate of $15.31 (average commercial rental rate among randomly selected properties in McAllen (Loopnet.com: McAllen Office Space for Lease available at: http://www.loopnetcom/Texas/McAllen_Office-Space-For-Lease/), the landlord's fit out allowance would be $45,930 (3,000 x $15.31); the net fit out cost to the tenant would be $854,070 ($900,000 - $45,930).

28. When preparing a pro forma for multi-specialty ASCs, my firm currently uses $700,000 per OR to estimate the equipment expense. In this instance, "equipment expense" refers to a range of items; these include capital items such as OR lights, anesthesia machines and sterilizers; expenses for furniture (clinical and administrative); clinical instrumentation expenses; and software and computer hardware costs. Others (Backer's ASC Review, "Establishing an Ambulatory Surgery Center: A Primer from A to Z.", 2012, available at: http://www.beckersasc.com/news-analysis/establishing-an-ambulatory-surgery-center-a-primer-from-a-to-z.html) state that equipment (only) expenses are about $250,000-$500,000 per OR. Considering that WWH-M already has much of the equipment (including certain capital items, instruments, etc.) for its current functioning (prior to closing the facility), I assume that $250,000 would be necessary to purchase equipment and related items that would bring the ASC for WWH-M in to compliance with Texas regulations.

29. Based on the information above, approximately $1,104,070 ($854,070 + $250,000) in capital spending would be necessary to establish an ASC for WWH-M.

30. If the $195 per square foot fit out expense my firm uses is applied in this situation, the total fit out expense would be $585,000 (3000 x $195), the net fit out cost to the tenant would be $539,070 ($585,000 - $45,930 (landlord's fit out allowance), architectural/engineering fees would be about $58,500 ($585,000 x 0.10) and equipment expenses would remain as above ($250,000). Accordingly, the tenant's total capital expenditures would be $847,570 ($539,070 + $58,500 + $250,000).

31. In my experience, banks providing fit out and equipment loans require an equity contribution from ASC owners of 20% or less of the total capital expense. Applied in this instance, lending institutions may seek an equity contribution of up to $220,814 ($1,104,070 x 0.2); the institutions then would provide financing for a total (fit out plus equipment) of $883,256 ($1,104,070 - $220,814) of capital expenses. If the lower figures associated with fit out at $195 per square foot are used, an equity contribution of up to $169,514 (847,570 x 0.2) may be necessary with a lending institution providing financing for $678,056 ($847,570 - $169,514) of capital expenses.

32. Considering the apparent common ownership within WWH, a consolidated balance sheet was

developed to assess the viability of WWH as a resource/ borrower for funds necessary to establish the ASC.

33. The 2013 consolidated balance sheet indicates that WWH has a current ratio of 1.11 and a debt to equity ratio of 2.09, both, in my experience, worthy of consideration to support bank lending. Notably, depending on the accounting treatment of the increase in net income (as it relates to "due to/due from" matters), these ratios may be enhanced if WWH's management fee were comparable with that paid by other ASCs.

34. According to balance sheet information provided by Plaintiff WWH, through Stirrups, LLC, WWH owns one or more buildings that cost approximately $911,803. (The balance sheet labels this asset "Building" However, the balance sheet also shows two long-term notes payable to Frost [Bank]; these appear to be mortgages, thus indicating that WWH, through Stirrups, may own more than one building.)

35. Presuming that the aforementioned long-term notes payable to Frost are mortgages, Stirrups has a total of approximately $467,230 ($157,145 + $310,085) of debt on the building(s) and equity of approximately $434,573 ($911,803 - $467,230).

36. A potential route that WWH could follow to finance the capital expenses needed to fit out an existing shell as an ASC is to take out a loan for $220,814 (or $169,514 under the alternative scenario) against the value of the building(s) (akin to a home equity loan), subordinate the notes payable that

appear to be due to individuals (e.g., Drs. Frisch, Kravitz, Tanz et al.), and seek financing of $883,256 from a lending institution.

37. In my experience, balance sheet information indicating "due **to** " an entity that is part of a common ownership group can indicate that the "parent company" did not want to (perhaps for tax purposes) recognize certain funds as income. Instead, the parent company recognizes these funds as a liability. If this is the case with WWH, funds may be available through WWH for a portion (e.g., a 20% capital contribution) or all of the capital needed to convert WWH-M to an ASC, or to fit out shell space as an ASC.

38. Alternatively, these same funds may be used to pursue one of the other approaches to establishing an ASC as noted above (time-share, etc.).

39. From a different angle, WWH may recruit equity partners and use the cash infusion (from the purchase of ownership interest(s)) to fund facility fit out as an ASC, leasing of a dormant ASC or to undertake one of the other options mentioned above.

40. Dr. Layne-Farrar introduces the concept of cost-benefit analysis (CBA) in in her direct testimony, and addresses one of the challenges of CBA. In fact, Section II of her testimony, which is a significant portion of the testimony, is entitled "Cost-Benefit Analysis of the ASC Requirement in HB2." I am perplexed by what seems to be contradictory information; on the one hand, Dr. Layne-Farrar says she

is addressing an "analysis of the likely costs and benefits deriving from the ASC requirement" but on the other hand, she states, "I do not attempt to attach numbers to subjective factors and instead only discuss those qualitatively." Based on my prior experience in designing and conducting medical economic analyses, including cost-benefit studies, such analyses require that one assign a particular unit of measure (usually dollars) to all the "costs" and "benefits" of a particular intervention or program. By her own admission, Dr. Layne-Farrar does not do this. Another tenet of CBA is that the analysis be done from a particular perspective. For example, a CBA might be done from a patient's perspective. In this case, one would examine the dollar value of all the costs incurred by a patient as well as the dollar value of all the benefits to the patient of a particular intervention, test or treatment modality. Similarly, a CBA may be done from a provider's perspective. Yet, Dr. Layne-Farrar does not maintain a consistent or singular perspective (or multiple analyses, each with a singular perspective) in her discussion. As such, I do not believe she has presented a cost-benefit analysis of the "ASC Requirement" and I cannot appreciate the applicability of the information she presents to the question at hand. More pointedly, in my opinion, Dr. Layne-Farrar does not present a CBA to support her conclusion (¶58 of her direct testimony) that "HB2's ASC licensing requirement will impose costs on women seeking abortion services in Texas that are far in excess of any expected benefits."

41. My opinions are based upon over three decades of health care experience, including over 20 years focusing on ambulatory surgery. In addition, my opinions are based upon my ongoing review of the health care management literature. In particular, in this matter I have consulted the following in forming:

- Nova Health Systems Profit & Loss Statements
- Whole Woman's Health Income Statements, Balance Sheets and associated documents
- Expert Report and Proposed Written Direct Testimony of Dr. Anne Layne-Farrar
- Expert Report and Proposed Written Direct Testimony of George Johannes
- Texas Administrative Code Chapters 135 & 139
- Texas Department of State Health Services—miscellaneous matters including, without limitation, ambulatory surgery center (ASC) listings and compilation of information reported annually by ASCs
- Texas Ambulatory Surgery Center Society
- Ambulatory Surgery Center Association
- VMG Ambulatory Surgery Center Financial & Operational Benchmarking Study 2012
- Miscellaneous documents regarding ASC development, size etc.

- Whole Woman's Health website. Available at: http://wholewomanshealth.com/.
- MLS Listing # 173892, Keller Williams Realty, available at: http://kwrgv.yourkwoffice.com/mcj/user/FeaturePropertyDetailAction.do?lhKey=3yd-KW-4308_173892
- Wajda M & Bell C. "Free-standing and Outpatient Surgery Centers." In American Society of Anesthesiologists, **2012 Operating Room Design Manual**, available at: https://www.asahq.org/For-Member/Practice-Management/ASA-Practice-Management-Resources/Operating-Room-Design-Manual.aspx).
- Design Cost Data Medical Square Foot Cost Guide available at: http://www.dcd.com/pdf_files/0903guide.pdf.
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42. I received my bachelor's degree in Health Planning in 1979 and my doctoral degree in Health

Services Research/Policy in 1983 from the University of Pennsylvania Broadly speaking, health services research/policy is a multi-disciplinary field that uses quantitative techniques to examine the effectiveness, efficiency, cost, decision-making patterns and other aspects of delivering or selecting health care.

43. Between 1979 and 1990, I served in various academic, research and administrative capacities at the University of Pennsylvania within the healthcare field. I have authored or co-authored 18 publications in peer-reviewed journals, 4 professional book chapters, and 33 abstracts for presentations at professional meetings. For fifteen years I was a Senior Fellow (Adjunct) at the Leonard Davis Institute for Health Economics. Additionally, I also served as a Lecturer in the Department of Anesthesia and a member of the Adjunct Faculty in the Section of General Medicine, all at the University of Pennsylvania For portions of this same period, I served as Co-Director for the Center for Research in Day Surgery, as Guest Faculty at the Wharton School in various health care courses and as a consultant to the Society for Ambulatory Anesthesia.

44. Immediately after leaving my positions at the University of Pennsylvania, I was the Director of Governors/Chapter Activities at the American College of Physicians, the national organization for internists. Subsequently, I was hired in 1989 to be the founding Executive Di rector of the Abington Surgical Center, one of the first ambulatory surgery centers (ASCs) to be developed in Pennsylvania. At the time I joined

Abington, construction had been partially completed on the facility. My initial task was to "operationalize" the ASC, meaning addressing all administrative, business and clinical matters necessary to open the facility as a state licensed, Medicare certified ASC. Among other matters, this involved hiring staff, establishing policies and procedures in compliance with state and federal regulations, recruiting practitioner-users, supervising completion of construction and equipment purchases, and addressing financing needs. I served as Executive Director of the facility for approximately nine years; during this time, patient volume grew to over 12,000 visits per year and profit margins were greater than 20% for each year after the first year of operations.

45. Between 1998 and 2000, I was the Vice President for Ambulatory Care and Assistant to the President and Chief Executive Officer of the Temple University Health System in Philadelphia In 2000, I formed Broshar Consulting, LLC, a regional health care consulting firm. I am the principal of Broshar. The single largest segment of Broshar's work has been with ASCs and includes single- and multi-specialty facilities, and facilities owned exclusively by practitioners or hospitals as well as facilities that have various joint venture arrangements. To date, Broshar has worked with over 70 ASCs. Our work for these ASCs has included carrying out feasibility assessments, guiding activities regarding obtaining licensure and certification, assisting to "operationalize" the facility, and providing management and

operational consulting. The overwhelming majority of Broshar's other work has been with hospitals (assisting with ambulatory surgery or regular operating room programs) and physician practices.

46. I serve as a Board member of the Pennsylvania Ambulatory Surgery Association and have done so for nearly 20 years. I recently was appointed to the Advisory Board of Physicians National Bank and I previously served on the Business Advisory Board of First Sterling/Prime Bank. Broshar is a member of the national Ambulatory Surgery Center Association and I am a member of the Medical Group Management Association.

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

Whole Woman's Health, et al., Plaintiffs, v. **David Lakey, M.D.**, Commissioner of the Texas Department of State Health Services, et al., Defendants.	Civil Action No. 1:1-cv-284-LY

DIRECT TESTIMONY OF PETER UHLENBERG, PH.D.

(Submitted Aug. 7, 2014)

1. My name is Dr. Peter Uhlenberg. I am a demographer and Professor of Sociology at the University of North Carolina at Chapel Hill. I have taught undergraduate and graduate courses and conducted research at this university for over 40 years. I am also a Fellow of the Carolina Population Center, an international interdisciplinary population research institute at UNC. I have published about 100 professional journal articles and book chapters, have held various editorial positions, and referee articles submitted to a number of professional journals in my field, including: *Demography, Social Forces, American Sociological Review, American Journal of Sociology, Journal of Marriage and Family, Population*

and Development Review, and *Population Research and Policy Review*.

2. In my work at the University I regularly teach and train graduate students in demography, population research methods, and sociology of the family. As part of my professional responsibilities, I frequently analyze and interpret data related to reproduction and abortion and review the literature on these topics. I am familiar with state abortion trends and have analyzed the impact of laws regulating abortion practices in various states.

3. The opinions I express herein are based on my education, training and research experience, in addition to my ongoing review and familiarity with the sociological literature. Facts or data I have considered in the formation of my opinions are cited below.

4. I provide these opinions in opposition to Plaintiffs' Complaint against enforcement of Texas House Bill 2, referred to herein as "the Act." I understand, among other provisions, that "a physician performing or inducing an abortion must, on the date the abortion is performed or induced, have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced and provides obstetrical or gynecological health care services ", and that all Texas abortion facilities must conform to the minimum standards of an ambulatory surgery center. I have reviewed the Plaintiffs' Complaint and Amended Motion for Preliminary Injunction related

to enforcement of the Act as applied to the McAllen clinic and the El Paso Clinic, as well as the reports of Plaintiffs' experts: Daniel Grossman, Lucy Felix, Kristine Hopkins, and Anne Layne-Farrar.

5. Plaintiffs object to the Act's requirement that all physicians who perform abortions have hospital admitting privileges at a hospital that is located not more than 30 miles from the location where the abortion is performed, and that effective September 1, 2014, all Texas abortion facilities conform to the minimum standards of an ambulatory surgery center (ASC). Plaintiffs argue that enforcement of the Act has forced both the McAllen clinic, i.e., Whole Woman's Health-McAllen, and the El Paso clinic, i.e., Reproductive Services, to cease providing abortions. Plaintiffs argue that these abortion clinics cannot continue to provide abortions because the doctors they have employed cannot obtain the required admitting privileges at a local hospital and that they are unable to find alternative doctors to provide abortions who meet the requirement. It is further argued that many patients who would obtain abortions at these two clinics would find it very difficult to travel to alternative clinics to obtain abortions. Further, it is argued that the ASC requirement would greatly reduce the number of abortion facilities in Texas, resulting in less access to abortion facilities for some individuals. I do not believe that the testimony of Plaintiffs' experts provide credible evidence that implementation of the Act would prevent a significant number of patients in Texas from obtaining the legal abortions they desire.

6. Plaintiffs' experts assume that the Reproductive Services clinic in El Paso and the Whole Woman's Health clinic in McAllen will permanently close or cease to provide abortion services because the clinics will not be able to meet the admitting privileges requirement of the Act. The Reproductive Services clinic in El Paso closed on June 1, 2014 allegedly because it was unable to hire an abortion physician meeting the admitting privileges requirement of the Act. The clinic's previous abortion provider, Dr. Pamela Richter, purports to have had temporary admitting privileges which expired in May, 2014. Gerri Laster, Administrator of the El Paso Clinic, stated in her Declaration in support of Plaintiffs' Motion for a Preliminary Injunction at ¶ 27, "As things stand, after May 13, 2014, the El Paso clinic will be unable to comply with the admitting privileges requirement." An April 2, 2014 article in the *El Paso Times* [http://www.elpasotimes.com/news/ci_25482076/el-paso-clinic-joins-challenge-texas-abortion-law] reports Laster as saying that: " her facility is working on another arrangement, but she declined to elaborate. She also declined to name the hospital at the hospital's request." Gerri Laster also stated in her Declaration at ¶ 28 that her clinic has been unable to recruit additional physicians to provide abortion services, and attributes this to the "hostility toward abortion in Texas." It is significant to note, however, that at least one physician who currently provides abortions in El Paso has admitting privileges. Dr. Franz Theard, who performs abortions at Hilltop Women's Reproductive Clinic in El Paso, Texas, has admitting privileges

at a local hospital [http://www.elpasotimes.com/news/ci_25482076/el-paso-clinic-joins-challenge-texas-abortion-law].

7. It is worth noting that recent claims have been made under oath that abortion providers could not obtain admitting privileges. These claims have proven to be false. In Texas, "Dr. Darrell Jordan, chief medical officer of plaintiff Planned Parenthood of Greater Texas, testified that his organization's clinics in Austin, Waco, and Dallas would "shut their doors" if the admitting privileges requirement of the Act should go into effect in 2013 [Case: 13-51008, Document: 005112576152, In the United States Court of Appeals for the Fifth Circuit filed March 27, 2014. Page 9. https://www.aclu.org/sites/default/files/assets/tx_fifth_circuit_3.pdf retrieved 3/30/2014]. However, a few months after the admitting privileges requirement went into effect, Planned Parenthood Clinics in Austin and Dallas were open and providing abortions. Planned Parenthood and the other abortion-provider plaintiffs in that case also relied on the Declaration of Dr. Joseph Potter who purported to offer an expert opinion that 2 of the 5 abortion clinics in Dallas County would close if the admitting privileges requirement was to go into effect. However, according to the testimony of Dr. Daniel Grossman (Table 1) 4 abortion clinics in Dallas were still open and providing abortions as of June 11, 2014. Another example is from North Dakota, where plaintiffs sought to block enforcement of a law requiring hospital admitting privileges for doctors providing abortions. The plaintiffs claimed that the admitting privileges requirement

would force the state's only abortion provider to close because its doctors could not obtain admitting privileges. However, a *New York Times* article on February 14, 2014 (http://www.nytimes.com/2014/02/14/us/north-dakota-abortion-doctors-get-hospital-privileges.html?_r=0) reported that physicians at the clinic have obtained admitting privileges at a local hospital and that the issue was settled without going to trial. Similarly, in a recent lawsuit challenging the Wisconsin admitting privileges requirement, an abortion clinic asserted that the admitting privileges requirement would force it to close. Before trial in May 2014, the abortion doctors at the Wisconsin abortion clinic obtained admitting privileges [http://www.theguardian.com/world/2014/may/27/wisconsin-abortion-providers-challenge-law-trial]. Thus, in my opinion, it is not clear that abortion clinics in El Paso and McAllen will be permanently closed as a result of the admitting privileges requirement of the Act.

8. Dr. Daniel Grossman's Expert Report relies largely on abortion data estimates collected and analyzed by the Texas Policy Evaluation Project (TexPEP) for the period from November 1, 2012 to April 30, 2014 (¶ 36). Recent abortion data, if reliable, would be highly relevant to answering questions about abortion trends in Texas since implementation of the admitting privileges requirement in November 2013. However, official data collected by the Texas Department of State Health Services for these recent time periods will not be available for some time and therefore the accuracy of the TexPEP data estimates cannot be verified. There are a number of issues,

however, which call into question the accuracy of the TexPEP data estimates and undermine the expert opinions that purport to rely upon this data.

9. First, it is important to consider Grossman's explanation of how the TexPEP data were collected and to identify significant omissions from the TexPEP data reported by Grossman (¶¶ 38-39):

- Licensed abortion facilities were asked to provide monthly statistics for the period from November 2012 through April 2014. The statistics requested were not only monthly number of abortions, but also type of abortion, gestational age, and whether the patient resided in the Lower Rio Grande Valley (RGV). These statistics might come from records kept by clinics, estimates provided by physicians who provided abortions and/or clinic administrators. (Grossman does not report the number or proportion of abortions that were based on physician or clinic administrator estimates. The number or proportion of patients from the Lower Rio Grande Valley that were based on clinic administrator estimates is also not reported.)

- For clinics that had closed, unidentified "knowledgeable sources" were asked to estimate the monthly number of abortions and the number of patients from the Lower Rio Grande Valley. (The number or proportion of closed clinics is not reported.)

- If there was no response from a clinic, other unidentified providers in the community

were asked to provide estimates of the monthly number of abortions at the non-responsive clinic and the number of patients from the Lower Rio Grande Valley was estimated based on the numbers reported by other clinics in the community with similar patient volume. (Grossman does not report the number or proportion of patients from the Lower Rio Grande Valley that were estimated based on numbers reported from clinics in the community with similar patient volume.)

- If no one could provide estimates, "internal estimates" were generated by TexPEP based on some other criteria described by Grossman as "based on the volume of other providers in the community or data we had for the facility for other periods." (The names of the facilities and the communities and volumes of other providers relied upon by TexPEP are not reported. The proportion of patients from the Lower Rio Grande Valley that were based on these "internal estimates" are also not reported.)

- Grossman's explanation shows that from November 2012 through April 2014 an average of approximately 11.1% of all TexPEP data was based on "knowledgeable sources" or "internal estimates." (Grossman does not report the proportion of the 11.1% that were identified by "knowledgeable sources" or "internal estimates" to be patients from the Lower Rio Grande Valley.)

10. The process TexPEP and Grossman used for collecting and analyzing recent abortion data may initially appear to be reasonable, but ultimately, there is a good deal of uncertainty regarding the accuracy of the data. Clearly the precise numbers given (e.g., 1,065 abortions to residents of the RGV between November 1, 2013 and April 30, 2014) cannot be accepted uncritically when Grossman acknowledges that the data was based in part on estimates provided by unidentified "knowledgeable sources", unnamed former employees of closed or non-responsive abortion clinics, data from unidentified abortion clinics "in the community", and TexPEP's unreported "internal estimates." In addition, because these data report abortions performed in Texas, there is no information on the number of abortions performed on women residing in other states and there is no information on the number of Texas residents obtaining abortions in other states. Further, it should also be noted that Plaintiffs have not provided to Defendants a large portion of the TexPEP data, estimates and underlying information relied upon by Grossman, and the accuracy and reliability therefore cannot be fully assessed.

11. Second, it is significant that TexPEP is the same source of data relied upon by Dr. Joseph Potter in his Declaration and purported expert testimony provided to this Court in support of Planned Parenthood's 2013 lawsuit challenging the constitutionality of the admitting privileges requirement of the Act. Using the data and analysis from TexPEP,

Potter testified that implementation of the admitting privileges requirement would "prevent at least 22,286 women from obtaining a safe and legal abortion in the next year, or, in other words, nearly one in three women" (See Potter Decl. at ¶ 7). According to the data in Table 2 of the Grossman Report, Grossman's estimated decline in the number of abortions in Texas in the first 6 months following implementation of the admitting privileges requirement of the Act was 1,811. On an annual basis, this decline would be 3,622 (i.e., 1,811 x 2). The estimate based on Grossman's data show the decline is approximately 16% of what was previously forecast by TexPEP and cited by Dr. Potter when he offered an expert opinion to this Court that the admitting privileges requirement would prevent 22,286 women from obtaining an abortion. Dr. Potter admitted at trial that TexPEP is funded entirely by pro-abortion donors, and that he conducted no independent evaluation of the accuracy of the TexPEP projections. Like Dr. Potter, Grossman relies entirely on TexPEP data which Grossman's estimates acknowledge was an inaccurate and grossly overstated projection of the effect of the admitting privileges requirement. The use of TexPEP data and analysis to predict abortion trends in Texas has been wildly in error in expert testimony previously presented to this Court and is an equally unreliable source of data for Grossman's opinions.

12. Grossman claims that looking at changes in the number of abortion providers in Texas from November 1, 2012 to April 30, 2014 and the estimated

decline in abortion rates discussed above "enables us to forecast the impact of the ASC requirement." After citing the TexPEP data, he writes: "The data described above provide strong evidence that the abortion facility closures have had a significant negative impact on women's ability to obtain abortion services in Texas. In my opinion, the best explanation for the decline in the Texas abortion rate is that some women who would have otherwise obtained abortion care were unable to negotiate the increased costs and travel distances that resulted from abortion facility closures."

13. Recent research provides good reasons to be cautious in claiming, based on simple correlations, that changes over time in number of abortion providers or new abortion laws are the cause of declines in abortion rates. In a 2014 article cited throughout Grossman's report, researchers from the Guttmacher Institute reported the findings from their study of why abortion rates in the US have been declining in recent years. In particular, they compare changes across states between 2008 and 2011 in number of abortion providers, new abortion laws, and abortion rates. They conclude: "The national abortion rate has resumed its decline, and *no evidence was found that the overall drop in abortion incidence was related to the decrease in providers or to restrictions implemented between 2008 and 2011.*" [Rachel K. Jones and Jenna Jerman. 2014. "Abortion Incidence and Service Availability In the United States, 2011," *Perspectives*

on Sexual and Reproductive Health, 46(1):3 (emphasis added)].

14. Even if we accept Grossman's estimated decline of 3,622 abortions in the year following the implementation of the Act, his opinion that this decline was caused by the implementation of the Act fails to address the significant fact that this decline is less than the decline occurring in the years preceding implementation of the Act. The number of abortions to residents of Texas declined by 4,956 between 2010 and 2011 and by 3,905 between 2011 and 2012. These declines between 2010 and 2011 and between 2011 and 2012 preceded implementation of the Act and were therefore not attributable to the Act. Nonetheless, Grossman assumes that the estimated decline of 3,622 abortions was caused solely by the Act, without considering whether all or part of this decline was attributable to other factors which had caused an even greater decline in the years immediately preceding implementation of the Act. Grossman's analysis does not control for other variables which are likely to have caused all or part of the estimated decline.

15. Grossman gives special attention to changes in the number of abortions to residents of the RGV over this period because the McAllen and Harlingen clinics purportedly stopped performing abortions after the admitting privileges requirement was implemented. The TexPEP data indicate that the number of reported abortions to residents of the RGV declined by 239 in the 6 months after November 1, 2013 compared to the preceding 6 months. Even if

one accepts the TexPEP estimates, it does not follow that closing of the RGV clinics caused this decline. In fact, the monthly average number of abortions to residents of the RGV was slightly higher in the 6 months after the McAllen and Harlingen clinics closed (177) than it was in 2012 when the clinics were open (169). Grossman's conclusion regarding causation is undermined by the fact that the average number of abortions to residents of the RGV was higher in the six months after the RGV clinics closed than in 2012 when those clinics were open.

16. Before concluding that a decline in number of abortion clinics results in a decreasing number of abortions, as argued by Grossman, it is necessary to consider the historical record in Texas. Many abortion clinics in Texas have closed in the past without a resulting decline in the number of abortions performed in Texas. In 2002 the number of Texas residents having abortions was 76,278. Between 2003 and 2006, approximately 25 abortion clinics closed in Texas [Texas Department of State Health Services, Center for Health Statistics. "Special Tabulation of Texas Abortion Clinic Licensees by Year Opened and Closed." 2014.]. Nevertheless, the number of abortions in Texas was greater in 2007 (77,811) than it was in 2002. A reasonable explanation is that when abortion clinics close (for whatever reason), existing abortion providers perform more abortions or new clinics open (11 new clinics opened between 2003 and 2006) to meet the demand for abortion services. The historical data shows that when demand for abortion

services in Texas is greater than the available supply of abortion services (e.g., as a result of clinic closures), existing abortion providers will expand their capacity and/or new abortion providers will open to provide additional services such that supply meets demand. In other words, Texas data shows that the market for abortion services follows basic principles of supply and demand. Data from other states supports the position that a decline in the number of abortion providers in a state does not necessarily have an effect on the abortion rate. For example, data collected by the Guttmacher Institute indicates that the number of abortion providers in Alabama declined from 13 in 2005 to 8 in 2008. Over this time period, however, the abortion rate in Alabama increased from 11.9 to 12.0.

17 In her testimony, Dr. Layne-Farrar states that if ASC regulations take effect on September 1, 2014, there will be fewer than 10 ASCs available to provide abortions in Texas, and all of these would be in the four largest metropolitan areas. Further, she argues, it is unlikely that new ASCs would be built to replace existing abortion clinics in other areas because of the cost of building and operating ASCs. If the only abortion providers in Texas were in Houston, San Antonio, Dallas-Fort Worth and Austin, the average distance to the nearest abortion facility for residents of Texas would be about 50 miles (Silvie Colman & Ted Joyce, 2011. "Regulating Abortion: Impact on Patients and Providers in Texas," 30 *Journal of Policy Analysis & Management* 30:779).

But no evidence has been provided to support the argument that new ASCs would not be opened. To the contrary, the response to earlier restrictions on facilities providing abortions past 15 weeks' gestation is instructive.

18. When the Woman's Right to Know Act, requiring that all abortions after 15 weeks' gestation be performed in an ASC went into effect in January 2004, no abortion providers met this requirement. In 2003 there were 3,642 abortions performed in Texas at or after 16 weeks' gestation. To meet this relatively modest demand for late term abortions, *four new ASCs were built in Texas in the following two years* (Silvie Colman & Ted Joyce, 2011. "Regulating Abortion: Impact on Patients and Providers in Texas," 30 *Journal of Policy Analysis &Management* 30:779). As a result of the opening of these four new ASCs, the average distance to the nearest provider of late-term abortion services fell from 252 miles in January 2004 to 53 miles in 2006. If four ASCs were built between 2004 and 2006 to meet a state-wide demand for fewer than 4,000 late-term abortions per year, it is conceivable that an ASC could be built in El Paso County where over 2,000 residents had abortions in 2012 and/or in the RGV where over 2,000 residents had abortions in 2012. Indeed, on their website, the Texas Women's Reproductive Health Initiative, Inc. ("TWRHI") [http://twrhi.org/ accessed June 25, 2014] describes a plan to construct new ASCs in Houston, Dallas and San Antonio "with additional facilities in less populated areas to follow."

TWRHI explained that the volume of abortions that an ASC facility can provide in a place like Houston or Dallas can generate the funds needed to support an abortion-providing ASC along the border, or in rural West Texas (http://rhrealitycheck.org/article/2013/10/21/new-non-profit-plans-construction-of-abortion-providing-ambulatory-surgical-centers-in-texas/). According to TWRHI's principal Charles Cohen, "with the support of facilities in major metropolitan areas, that's a sustainable business model." (http://rhrealitycheck.org/article/2013/10/21/new-non-profit-plans-construction-of-abortion-providing-ambulatory-surgical-centers-in-texas/).

19. Grossman raises the question of whether ASCs would be able to meet the demand for abortion services if all non-ASC clinics in Texas close. Notably, Grossman does not offer an opinion regarding statewide capacity. Rather he merely speculates that in Dallas-Fort Worth and San Antonio, the existing ASCs will not be able to meet demand if all of the non-ASC clinics close by September 2014. However, both Planned Parenthood and TWRHI have announced their intentions to build new ASCs and/or have described a business model that would support new ASCs in major metropolitan areas as well as less-populated areas of Texas.

20. Further, the growth in the proportion of all Texas abortions performed in ASCs in the years before Texas House Bill No. 2 was first debated in 2012 is impressive. Statistics on abortions by type of facility are available from the Texas Vital Statistics

Annual Reports (http://www.dshs.state.tx.us/chs/vstat/annrpts.shtm). From 2005 through 2009, between 6% and 8% of all abortions were performed in ASCs. This proportion nearly doubled in 2010 (12.7%) and then nearly doubled again in 2011 (22.4%). Clearly, for seven years prior to the enactment of the ASC requirement of H.B. 2, Texas abortion provider have opened new ASCs, consistently expanded ASC abortion capacity, and have increasingly chosen on their own to perform abortions in ASCs. Plaintiffs' experts have not provided any reliable evidence or data to show that this trend will not continue or that abortion patients in Texas will be unable to obtain abortion services at ASCs.

21. Both Dr. Grossman and Dr. Layne-Farrar discuss the distance that certain abortion patients in Texas would need to travel to obtain an abortion if the nearest abortion clinic were to close. Grossman considers the number of women of reproductive age in Texas living certain distances from a clinic providing abortions in Texas and estimates that, since the implementation of the admitting privileges requirement, the number of women of reproductive age in Texas living more than 50 miles from a clinic has increased from 816,000 to 1,680,000, the number of women living more than 100 miles from a clinic increased from 417,000 to 1,020,000, and the number of women living more than 200 miles from a clinic increased from 10,000 to 290,000. Grossman opines that "the best explanation for the decline in the Texas abortion rate [since the implementation of the admitting privileges requirement] is that some women

who would have otherwise obtained abortion care were unable to negotiate the increased costs and travel distances." Grossman further opines that the ASC requirement will cause additional clinic closures and "significantly increase distances that women in South and West Texas must travel to obtain abortion services." Grossman's opinions are flawed for the following reasons.

22. First, it is important to recognize, that for many women residing in Texas the nearest abortion provider is not located in Texas and that abortion patients frequently travel to abortion clinics located in other states. For example, if no abortion clinic was available in El Paso, patients would not need to travel to San Antonio. Rather, they could travel to the Hilltop Women's Reproductive Clinic located in Santa Theresa, New Mexico (about 13 miles from El Paso), which is owned and operated by the same physician who owns and operates the Hilltop Women's Reproductive Clinic located in El Paso, Texas. Abortion patients in El Paso could also travel to an abortion clinic in Albuquerque, New Mexico in half the time it would take to drive to San Antonio (3h41m vs. 7h33m, using Google Maps).

23. It is not uncommon for women to go out of state to obtain abortions. Complete data on the number of women obtaining out of state abortions are not available because not all states report this information. However, the CDC's Abortion Surveillance website (http://www.cdc.gov/reproductivehealth/data_stats/Abortion.htm accessed 6/27/2014) provides a

downloadable file, "Abortions Distributed by State of Maternal Residence and State of Clinical Service", containing all available data. These data indicate that more than 50% of the abortions to residents of Mississippi, Missouri and Wyoming occurred in other states. These data also show that more than 30% of the abortions to residents of Idaho, Kentucky and South Carolina occurred in other states. All of the states with a large proportion of abortions to residents occurring in other states, except Wyoming, had an abortion clinic. The data from these states suggest that abortion patients frequently travel to out-of-state abortion clinics when they find those clinics preferable to in-state clinics or when out-of-state clinics are located closer to their residences. It is unreasonable for Grossman and Layne-Farrar to assume that women living in the El Paso will be required to travel to San Antonio if existing abortion clinics in El Paso cease to provide abortion services.

24. Second, Grossman cites a study (Jones, RK, Jerman J. "How Far Did US Women Travel for Abortion Services in 2008?" J Women's Health. 2013 Aug; 22(8): 706-13) to support his assertion that the distances women would be required to travel for abortion services in Texas after implementation of the ASC requirement "are much greater than the national mean distance traveled to an abortion clinic, which was 30 miles in 2008; only 6% of abortion patients travelled more than 100 miles." Grossman fails to note the study's finding that in 2008, 9.8% of women living in the South, and 31% of women living in rural

areas, traveled over 100 miles for abortion services which "reflects the fact that women residing in rural areas have to travel farther for all kinds of services, including basic health care and even necessities such as groceries."

25. Lucy Felix, Kristine Hopkins and Anne Layne-Farrar describe what they and Plaintiffs' other experts perceive to be financial and time-management burdens experienced by women living in the RGV who seek abortions at facilities located elsewhere in the State. Based upon her experience as a community health educator in the RGV, Lucy Felix describes her view of hardships facing individuals living in the RGV. There is no reason to question her perceptions about the experiences of those living in poverty that she sees in that region. But she goes on to opine that the closure of the McAllen clinic will keep potential abortion patients from accessing legal abortion services. She writes, "I believe that a large proportion of them will be unable to do so." Because she presents no information that directly addresses the question of what choices pregnant women in the RGV desiring an abortion would in fact make, we have only her speculation about how individuals might make such a decision. Based solely on her assumptions regarding travel time, travel costs, childcare, and time off from work, she speculates that many low-income abortion patients would decide not to obtain an abortion. Felix provides no basis for her assumptions and speculation. She does not explain why these potential abortion patients would choose to forgo abortion-related

travel rather than other expenses, and, significantly, she does not consider the alternative cost these women would incur should they decide not to have an abortion, i.e., the cost of raising a child. The costs of raising a child can be considerable. The United States Department of Agriculture provides estimates of expenditures on children by families at different income levels (http://www.cnpp.usda.gov/Publications/CRC/crc2012.pdf). For a low income family (average income = $26,900) in 2012, the average cost of raising a child is $42,390 for the first 5 years of life, and $161,220 for the first 17 years of life. It is probably unreasonable to assume that most individuals know this statistic, but it is not unreasonable to assume that individuals know that having and raising a child is expensive—many times more expensive than having an abortion. To suggest that low-income abortion patients do not consider the costs of raising a child (direct expenses plus opportunity costs) in making a decision regarding abortion is speculation based solely on the unsupported notion that low-income women lack rational decision making abilities.

26. Kristine Hopkins provides information on levels of poverty, uninsurance and teen pregnancy in the RGV and El Paso County. She also reports data on pregnancies and abortions for women aged 15-44, and concludes that women living in the RGV and El Paso County would "find it very difficult to travel outside the region in which they reside to access abortion care." She does not rely on any data or evidence to support this assertion. To assess Hopkins'

opinions regarding the effect of the Act on Texas residents, it is important to note the following:

- In 2011, less than 7% (6.9%) of the abortions performed in Texas were obtained by women residing in the RGV and El Paso County. In 2012 6.4% of abortions performed in Texas were obtained by women residing in the RGV and El Paso County. (Data are from Table 34 in Texas Vital Statistics Annual Reports, 2011 and 2012, Texas Department of State Health Services). [The number of abortions for residents of RGV counties reported in Table 4 of Hopkins' report is wrong—she incorrectly added the abortions in El Paso County to those in RGV counties. She also makes this error on page 5 of her report.]

- The discussion of teen births is of limited relevance. Only 0.2% (151/70,003) of the abortions to residents of Texas in 2011 occurred to teens aged 13-17 residing in the RGV and El Paso County. No evidence is provided to indicate that teens desiring abortions in the RGV and El Paso County are unable to obtain them. The termination of teen pregnancy by abortion is relatively uncommon in these regions—the ratio of abortions to births for girls aged 13-17 was much lower in RGV and El Paso County in 2011 (when abortion clinics were operating in both areas) than in Texas as a whole (.067 and .084 vs. .159).

While Hopkins' assertion that the costs of an abortion present "substantial obstacles to accessing" abortion

for low-income women may seem like a reasonable assertion, she fails to consider the relative costs of an abortion and the costs of raising a child. (See ¶ 25 above)

27 In the context of this lawsuit, it is worth noting that the Fifth Circuit Court of Appeals determined in a previous case that traveling from the RGV to Corpus Christi (a driving distance of approximately 160 miles, using Google Maps) to obtain an abortion was not an undue burden. All of the burdens described by Felix, Hopkins, Layne-Farrar and Plaintiffs' other experts in this lawsuit are burdens that would be experienced by women travelling 160 miles from the RGV to Corpus Christi. Plaintiffs' experts do not describe, or offer any opinion on, the additional burden of traveling the extra 100 miles from the RGV to San Antonio. If one assumes that women in the RGV will not be deterred in significant numbers by the costs of traveling to Corpus Christi to obtain an abortion, there is no reason to assume they will be deterred in significant numbers by the costs of traveling an additional 100 miles to obtain an abortion in San Antonio.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

Whole Woman's Health; Austin Women's Health Center; Killeen Women's Center; Nova Health Systems d/b/a Reproductive Services; and Sherwood C. Lynn, Jr., M.D.; Pamela J. Richter, D.O.; and Lendol L. Davis, M.D., on behalf of themselves and their patients, Plaintiffs, v. **David Lakey, M.D. and Mari Robinson,** in their official capacities, Defendants.	Civil Action No. 1:14-cv-284-LY

DIRECT TESTIMONY OF NAGLA ELERIAN

(Submitted Aug. 7, 2014)

My name is Nagla Elerian. I am the director of the Center for Health Statistics at the Texas Department of State Health Services ("DSHS"). Among other duties, my department is responsible for collecting Abortion Complications Reporting forms provided to DSHS pursuant to 25 Texas Administrative Code 139.5. I have reviewed Defendants' Exhibits 36, 37, and 38. Exhibit 36 contains true and correct copies of

all Abortion Complications Reporting forms received by DSHS between January 1, 2013 and June 1, 2014 from all Whole Woman's Health facilities, including Whole Woman's Health's Austin, Fort Worth, McAllen, San Antonio, and Beaumont locations. Exhibit 37 contains true and correct copies of Abortion Complication Reporting forms submitted to DSHS by the Austin Women's Health Center and the Killeen Woman's Health Center. Exhibit 38 contains true and correct copies of Abortion Complication Reporting forms submitted to DSHS by Nova Health Systems dba Reproductive Services.

Supreme Court, U.S.
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No. 15-274

In The Supreme Court of the United States

WHOLE WOMAN'S HEALTH ET AL. PETITIONERS

v.

KIRK COLE, M.D., COMMISSIONER OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

JOINT APPENDIX VOLUME VII

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH, ABORTION ADVANTAGE, AUSTIN WOMAN'S HEALTH CENTER, KILLEEN WOMAN'S HEALTH CENTER, NOVA HEALTH SYSTEMS, SHERWOOD C. LYNN, JR. M.D., PAMELA J. RICHTER D.O., LENDOL L. DAVIS M.D.,	AU:14-CV-00284-LY
VS.	AUSTIN, TEXAS
DAVID LAKEY M.D., MARI ROBINSON.	AUGUST 7, 2014

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TRANSCRIPT OF BENCH TRIAL
BEFORE THE HONORABLE LEE YEAKEL

VOLUME 4 OF 5

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[6] TODD GIBERSON,

having been first duly sworn, testified as follows:

REDIRECT EXAMINATION (CONTINUED)

BY MR. STEPHENS:

Q. Good morning, Mr. Giberson.

A. Good morning.

Q. Mr. Giberson, yesterday we were discussing this map that you prepared as part of your direct testimony that you've given in this case. Do you recall that?

A. Yes.

Q. And in connection with your testimony about the map that you just saw, we were also discussing this table that you—that you prepared; is that right?

A. That is correct.

Q. And could you describe again for the Court what each of those percentages on the third column on the right of this table represent?

A. After—as you saw on the map, I created boundaries around different regions, areas in the State that enclosed travel distances from provider facilities outward—using 150 [7] miles. And the percentages in the far right column represent the number of women of 15 to 44 age range in the State within those various areas.

Q. Okay. You were asked a question yesterday on cross-examination by Plaintiffs' counsel about the census data that you used and potential growth in the State of Texas. Do you recall that questioning?

A. Yes. Yes.

Q. And I believe you were asked whether that would affect the analysis that you've provided in table 2; is that right?

A. I mentioned that Texas had grown, yes, since 2010. Assuming the growth in the State was uniform across the State, the percentages wouldn't change at all. In fact, though, the greatest rate of growth has occurred for the past many years in the suburban ring counties around major urban areas.

For example, here in Travis County, we know Williamson County and Hays County are among the fastest growing in the State. Same things occurs with Montgomery County, Fort Bend near Houston, and Denton and Collin Counties north of Dallas/Fort Worth. Those are the fastest growing areas in the State. Also, though, Laredo and McAllen, the Harlingen and Brownsville area are fast growing as well.

Q. Okay. So if the greatest growth is occurring in the metropolitan areas—the major metropolitan areas you mentioned around Dallas, I think Austin and Houston were the [8] three that you mentioned—how would that affect the percentage of females age 15 to 44 in the State that are included within the area one on your map?

A. Well, you would see—you would see that number where it was 83.3 percent, we'd tick up probably a little bit, maybe. I don't know how much, but it certainly wouldn't go down as a percent.

Q. It would likely go up?

A. It would likely go up, slightly.

MR. STEPHENS: Your Honor, the State would like to move for admission of exhibits—Defendants' Exhibits 40, 41, 42, and 43, which are the two maps and the two tables that Mr. Giberson has testified that he prepared as part of his expert testimony—or as part of his opinion in this case.

MS. BHANDARI: No objection, Your Honor.

THE COURT: Defendants Exhibits 40, 41, 42, and 43 are admitted.

MR. STEPHENS: No further questions, Your Honor.

THE COURT: Further recross?

MS. BHANDARI: Yes, Your Honor.

RECROSS-EXAMINATION

BY MS. BHANDARI:

Q. Mr. Giberson, you were asked some questions regarding the three-hour travel time. Do you recall those questions?

A. Yes.

[9] Q. Okay. Have you ever sat in traffic on Interstate 35?

A. Yes, I have.

Q. And has that traffic been particularly heavy around a major city such as Austin?

A. Yes. When I—when I say travel time, I'm talking about normal travel conditions. Of course, it varies with—nowadays particularly, there are sophisticated map services that will take into account accidents or—or rush hour traffic, and it would be a longer travel time.

Q. So your three-hour travel time analysis doesn't take into account rush hour traffic; is that correct?

A. That's correct.

Q. So women who hit rush hour traffic, say, entering Dallas or Austin, it could take her more than three hours; is that correct?

A. Yes. That's correct.

Q. Okay. Your three-hour travel time analysis doesn't include something such as waiting for a bus at a bus stop; is that correct?

A. That would be correct.

Q. And it wouldn't include the time to possibly change buses?

A. Correct.

Q. And it also wouldn't include travel time from a woman's home to a bus stop; is that correct?

A. That's correct.

[10] Q. Okay. You had just mentioned in response to some questions from the State's attorney

regarding the growth of certain population areas. Do you recall those questions?

A. Yes.

Q. And you mentioned that Harlingen, Brownsville, and McAllen are some of the fastest growing cities in Texas; is that correct?

A. Among the fastest growing, yes.

Q. So that means that the absolute number of women of reproductive age in those cities is also growing; is that correct?

A. Correct.

Q. Okay. And do you know that the admitting privileges requirement in this case requires a—an abortion provider to have admitting privileges at a hospital within 30 miles of the provider facility?

A. That's what I understand from the law, yes.

Q. So if a woman was living at the edge of the 150-mile boundary that you drew and drove to a provider facility 150 miles away and then drove home 150 miles, that means that she would be at least 120 miles from the hospital at which a provider has privileges; is that correct?

A. I'm sorry?

Q. If she drove back home and she was 150 miles from the provider facility and that provider had

privileges at a [11] hospital within 30 miles, she would be 120 miles from that hospital; is that correct?

A. I would assume that's right.

Q. Okay. Thank you.

MS. BHANDARI: No further questions.

THE COURT: Mr. Stephens, anything further?

MR. STEPHENS: No, Your Honor.

THE COURT: All right. The witness may step down.

MR. STEPHENS: Your Honor, the State will call a Nagla Elerian.

(Witness sworn)

THE COURT: You may proceed.

MR. SOTO: Good morning, Your Honor. Esteban Soto for the State defendants.

NAGLA ELERIAN,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. SOTO:

Q. Can you please introduce yourself to the Court.

A. Sure. My name is Nagla Elerian.

Q. And can you open up the binder to you—on your desk in front of you that has direct testimony. I believe it's seven.

A. (Complies)

Q. Have you reviewed this document before?

A. Yes, I have.

[12] Q. And does this direct testimony reflect—is this—does this reflect the true and accurate testimony that you're giving here today?

A. Yes.

MR. SOTO: Your Honor, at this time we'd move to introduce the direct testimony of Nagla Elerian into evidence and with that also Exhibits 36, 37, and 38—Defendants' exhibits.

THE COURT: I reflect that Defendants' Exhibits 36, 37, and 38 have previously been admitted.

MR. SOTO: All right. Thank you, Your Honor. And with that, we pass the witness.

THE COURT: Any objection to the direct testimony of Nagla Elerian?

MS. TOTI: No, Your Honor.

THE COURT: All right. Then the document entitled—the statement entitled Direct Testimony of Nagla Elerian is admitted.

You may proceed.

CROSS-EXAMINATION

BY MS. TOTI:

Q. Just very briefly. Good morning, Ms. Elerian. Nice to see you again.

A. You, too.

Q. So the exhibits that are referred to in your direct [13] testimony are abortion complications reporting forms that have been received by the Department of State Health Services; is that correct?

A. That's correct.

Q. Who is responsible for submitting these forms?

A. The abortion facilities are responsible for submitting these form to the department.

Q. Is it your understanding that the facilities have a responsibility to submit the forms or that individual physicians have a responsibility to submit the forms?

A. I'm not sure exactly the very specifics of whether it's the provider or the facility itself.

Q. And are abortion providers the only people that are responsible for submitting these forms?

A. That's my understanding, yes.

Q. So isn't it the case that—pardon me—any physician who treats a patient experiencing an abortion-related complication has an obligation to submit the forms?

A. I'm not in the regulatory. We just receive the forms as we get them.

Q. So—so you can't verify the content of forms?

A. What we do when we get the forms is we just make sure that they're submitted correctly per our required—the required reporting, and then we pass it on to regulatory.

Q. And what steps do you take to ensure that a form has been [14] submitted correctly?

A. What we do is we make sure that the addresses or the facility names are correct. We make sure that the dates that were submitted accurately reflect the period of reporting. And also on the forms there's a comment or a summary, and there is also a check box on complications. What we do is we just verify that the information in the summary was reflected in the check box. And that's basically what we do.

Q. I see. So if you are verifying the address of the facility, then you must be aware that these forms

are sometimes submitted by facilities that aren't licensed abortion providers; is that correct?

A. Yes.

Q. Sometimes they're submitted by hospitals that treat a patient who is experiencing abortion complication; is that correct?

A. I have—I do not know. I have not reviewed the forms to know what exact facilities have submitted. We do not analyze these reports. We just pass them along.

Q. And suppose for a moment that any physician who treats an abortion-related complication has an obligation under the law to submit a form to the department and any physician that's aware of an abortion-related complication for a patient that he or she has treated has an obligation to submit the form to the department.

[15] If that were the case and a patient presented at the hospital for treatment for an abortion-related complication and notified the clinic that she had gone to the hospital, you would expect to receive two forms concerning that patient's complication; is that correct?

A. It depends, I think, on whether both are aware of the complication. So if the original clinic is aware of the complication, then I would expect that. But there's no way for my area to verify it.

Q. Right. And then suppose that, you know, upon leaving the hospital, the patient later followed up with her primary care physician and filled that physician in, you know, on the complication and whatever follow-up treatment. You would then expect to receive a form from that primary care physician as well documenting the abortion-related complication, wouldn't you?

A. Again, I am not intimately familiar with the rules related to the reporting.

Q. Okay. But so it's possible that, for any given complication, the forms could be submitted in duplicate or triplicate or perhaps even more than that, correct?

A. Again, I'm not familiar with the specifics regarding the rules.

Q. So this—this just isn't your area?

A. We, again, receive the information and pass it along. We [16] do not analyze the information or regulate it.

Q. So you are not able to provide any testimony on behalf of the State that each complication reporting form represents one patient's complication; is that correct?

A. I am only able to provide testimony regarding the forms that we have in our possession.

Q. I understand. I'm going to ask it one more time because I think I asked a poor question, just for the record. And I apologize.

You are not in the position to offer any testimony on behalf of the State today that each abortion complications reporting form represents a unique patient complication. Is that fair?

A. Correct.

Q. And can you tell me a little bit about the chain of custody for these forms? What happens from the time that they are received at the department, who receives them, and what are all the steps that they go through until they end up somewhere?

A. So I can speak to the Center For Health Statistics. What we do is once they're—we receive those forms, they're logged in and they're verified, just checked, to make sure that the addresses are accurate on there, that we have—the dates are within the range for the reporting period. Then we check the complication check box against the summary. And if there are any concerns about the ranges of the dates or anything else, we [17] call up the facility to verify the information.

Once the information is verified, it is scanned, and—and then it's sent within a couple of days to regulatory. And that's when it's out of—the center no longer works with the data. It's—we have it filed, the actual paper form, and it's retained for two years.

Q. And the forms that were provided to Defendants' counsel for inclusion in the exhibit, who provided those forms? Where did they come from within the agency?

A. The forms in the exhibit?

Q. Yes.

A. So we provided those. We had them. We're the ones who received them from the facilities.

Q. So they—they came from your division, not the regulatory division?

A. Correct.

Q. And how long is it from when the forms are typically received in paper format to when they are scanned in and become electronic?

A. Usually within about two days of receipt.

Q. And do forms ever get lost?

A. To my understanding, I'm not aware that they would be.

Q. But it's possible that they could get lost?

A. They are received in a PO box specific for this report. Once they are received, they're logged in and entered. So we [18] have checks and balances.

Q. But it's possible that—that a form along the way could inadvertently not be scanned?

A. I'm not aware that that would happen. That's why, again, my staff have checks and balances, to make sure.

Q. All right. Thank you.

MS. TOTI: No further questions, Your Honor.

THE COURT: Mr. Soto?

MR. SOTO: Very brief, Your Honor.

REDIRECT EXAMINATION

BY MR. SOTO:

Q. Ms. Elerian, are you familiar with the forms contained in Defense Exhibit 36?

A. Yes, I am.

Q. And do these represent all of the forms that the Texas Department of State Health Services has received by Whole Woman's Health from January 1st, 2013 through June 1st, 2014?

A. That's correct, yes.

MR. SOTO: Pass the witness, Your Honor.

THE COURT: Anything further, Ms. Toti?

MS. TOTI: Just very briefly, Your Honor.

RECROSS-EXAMINATION

BY MS. TOTI:

Q. Wouldn't it be more accurate to say, Ms. Elerian, that these forms represent all of the records that you currently [19] have in your system that were received from physicians in the State of Texas?

A. These are the abortion complication reporting forms received during that period of time for Whole Woman's Health for Exhibit 36. And then Exhibit 37, it's Austin Woman's Health Center in Killeen. And then Exhibit 38, abortion complication reporting from Nova Health System.

Q. Right. But you—you can't know whether those are all the forms that were submitted, correct?

A. These are all the forms that were received by the Department of State Health Services.

Q. That were received by the department and scanned into the system. Would that be fair?

A. That were received in the department, they're filed, and so these are copies of the filed reports. In addition, yes, they are scanned and sent to regulatory.

MS. TOTI: Thank you.

THE WITNESS: Sure.

MR. SOTO: No further questions, Your Honor.

THE COURT: You may step down.

MS. KANE: Your Honor the defendants would like to call Dr. Deborah Kitz to the stand.

(Witness sworn)

****

[20] DEBORAH S. KITZ,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. KANE:

Q. Good morning.

A. Good morning.

Q. Would you please state your full name for the record.

A. Sure. Deborah S. Kitz.

Q. And, Dr. Kitz, are you currently employed?

A. Yes.

Q. And where are you employed?

A. I'm self-employed at Broshar Consulting.

Q. And what do you do in that position?

A. I am the principal of Broshar Consulting.

Q. And what does Broshar Consulting do?

A. Broshar Consulting is a regional health care consulting firm, and the single largest segment of our work is with ambulatory surgery centers. Some of our other work is with hospitals and physician practices.

Q. Thank you. Now, I believe you might have a binder in front of you that has various written direct testimonies in it; is that correct?

A. Yes.

Q. And can you turn to the tab that is marked with your name. Or if it's not marked with your name, can you locate your [21] testimony?

A. It's under tab 4, I believe.

Q. Thank you. And do you recognize the document?

A. Yes.

Q. And what do you understand it to be?

A. It is the direct testimony with regard to my report.

Q. So it is your direct testimony?

A. Yes.

Q. Okay. And have you had an opportunity to review that document before today?

A. Yes.

Q. Okay. And are the statements in that document true and correct?

A. Yes.

Q. And are the opinions expressed in that document your opinions?

A. Yes, they are.

Q. In preparing that document, did you have any communications with a person by the name of Dr. Vince Rue?

A. Yes.

Q. And do you know who Dr. Rue is?

A. Yes. It's my understanding that he's a consultant to the Attorney General's Office.

Q. Okay. And who drafted your testimony?

A. I did.

[22] Q. Okay. And did your communications with Dr. Rue change the opinions that you're offering today in this suit?

A. No.

Q. Okay. Are the opinions in your testimony you own opinions?

A. Yes, they are.

Q. And do you stand by the statements and opinions in your written testimony?

A. I do.

MS. KANE: At this time, Your Honor, we'd like to offer into evidence the written direct testimony of Dr. Deborah Kitz?

MR. LAWRENCE: Your Honor, we do have two objections. One is on *Daubert* grounds. And as we've done in the past, we'll reserve on that until Your Honor has had a chance to hear the testimony.

Secondly, if I could approach, Your Honor?

THE COURT: You may.

MR. LAWRENCE: Your Honor, we object to paragraphs, in particular, 9 through 16, 18, and 31 through 39 of Dr. Kitz's direct testimony. And, Your Honor, we had a scheduling order in this case that said that expert reports would be due on June 16th.

The defendants—and this is well within their rights if this is what they wanted to do. They decided we're [23] not going to submit expert reports on the 16th. What we're going to do is make a strategic decision, even though they were ready to roll, they say, to hold those back and to submit rebuttal reports. And that's fine if what they're going to do is submit rebuttal testimony.

But what Dr. Kitz has done in her testimony and in her report is she's opining on facts that none of our experts opine on. And that, specifically, Your Honor is the financial wherewithal of the plaintiffs in this case to shell out $3 million or whatever it is—and we—I understand that's in dispute—to build one of these facilities that complies with the ASC requirement.

There's been no testimony from the plaintiffs' experts. The two in particular that Dr. Kitz says she's rebutting are Mr. Johannes and Dr. Layne-Farrar. Dr. Kitz conceded in her deposition, looking through those reports, that there's nothing in those reports about the financial wherewithal of the plaintiffs to afford the $3 million that it costs to build one of these facilities. Obviously, that doesn't even account for the cost of the land.

But, in any event, this is—it's improper rebuttal testimony, and there is case law that we could point you to that you just can't do that. If you're going to put in rebuttal, it needs to be rebuttal. If you want to have your own expert opinions, there was a time to do that. That was on [24] the 16th. And State defendants decided strategically not to do it.

THE COURT: Ms. Kane?

MS. KANE: Your Honor, as you're aware, one of the issues in this case that's been raised by Defendants through their experts is the cost of compliance with the ASC requirement. And our—the position of the State is, of course, not only does that involve this abstract idea of what it might cost independent of any entity, but the—because the plaintiffs here at issue are specifically saying that it is difficult for them from an expense standpoint to operate an ASC, obviously, part and parcel of that issue is whether or not these defendant—these plaintiffs can potentially afford to comply with the requirement.

So to the extent that is essentially part and parcel of the opinion of Dr. Johannes implicitly when he is talking—opining on the expenses as he believes them to be of complying with the ASC requirement, this is a response to that. And there is—it's clearly part of the case and clearly keys off of his opinions regarding the cost of the ASC requirement.

THE COURT: Do you perceive the expert report of Dr. Kitz to be direct expert testimony proffered by the State, or do you intend it to be rebuttal testimony?

MS. KANE: We're offering it as rebuttal testimony with respect to the burden of the expense, Your Honor.

[25] THE COURT: All right. The objection is sustained to the extent the direct testimony of Ms. Kitz, as reference by the plaintiffs, could be construed to be direct expert testimony. It is overruled to the extent that it is rebuttal testimony in response to the expert reports and testimony of Mr. Johannes and Dr. Layne-Farrar and will be considered by the Court solely as rebuttal to the statements made in those reports and for no other purpose.

MS. KANE: And, otherwise, the exhibit is admitted, Your Honor?

THE COURT: Otherwise, the document entitled Direct Testimony of Deborah Kitz, Ph.D., is admitted.

MR. LAWRENCE: And just for the record, Your Honor, it's paragraphs 9 through 16, 18, and 31 through 39 which are solely about the financial wherewithal of the plaintiffs.

THE COURT: All right. Give me those paragraphs numbers again.

MR. LAWRENCE: Yes, Your Honor. Nine through 16, paragraph 18, and paragraphs 31 through 39.

THE COURT: All right.

MS. KANE: And, Your Honor, I would like to note for the record that the State's position remains that those paragraphs are not being offered as direct evidence, but that they are relevant in rebuttal to the issue of the burden of the expense.

[26] THE COURT: They're only going to be considered as rebuttal expert testimony in response to evidence proffered by the experts mentioned on behalf of the plaintiffs.

MS. KANE: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. LAWRENCE:

Q. That's your deposition.

A. Okay.

Q. So good morning, Dr. Kitz.

A. Good morning.

Q. You were deposed in this case, right?

A. I'm sorry. I didn't hear you.

Q. I'm sorry. You were deposed in this case, right?

A. Twice.

Q. Okay. And you understood when you were deposed that you were under oath, correct?

A. Yes.

Q. Dr. Kitz, you were recruited to serve as an expert witness in this case by Vincent Rue; is that right?

A. Yes.

Q. And at your deposition you were asked: Did anyone else contribute to writing your report? Do you recall that?

A. Yes.

Q. And you responded no?

A. Correct.

[27] Q. Do you recall that?

A. Correct.

Q. And that wasn't true, was it?

A. It was true in that the—as I mentioned, that various editorial changes were made, that format was suggested by Mr. Rue, that I received some comments and suggestions from the State, some of which I didn't take. But all the substance was mine.

Q. So when you were asked if anyone else contributed to writing it and you responded no, that was partly true?

A. When I think of writing it, I think of the substance, not editing.

Q. Dr. Kitz, do you recall the first draft of your report in this case?

A. In vague terms, yes.

Q. Do you recall when you first sent that report to Mr. Rue?

A. Not precisely, no.

Q. Dr. Kitz, can you see that in your screen?

A. Yes.

Q. Wonderful. If you look at the bottom E-mail in the chain, does that refresh your recollection of when you first sent your draft report to Mr. Rue?

A. I don't remember whether this was the first one but, certainly, it was sending a draft.

Q. And do you recall that the—what you first sent to [28] Mr. Rue was just a series of bullet points?

A. Yes.

Q. Dr. Kitz, you see that you sent this bullet point draft to Mr. Rue on June 6th by E-mail, right?

A. Correct.

Q. And do you still have that E-mail?

A. I should, yes.

Q. Were you asked to provide that E-mail to the Attorney General's Office?

A. No.

Q. Were you asked to provide any E-mail to the Attorney General's Office?

A. No.

Q. Were you asked to provide any documents to the Attorney General's Office?

A. Just my report.

MR. LAWRENCE: And I would like to mark this for identification as 218, Your Honor. It's DSHS 00062510.

Q. (BY MR. LAWRENCE) Now, Dr. Kitz, do you recall Mr. Rue getting back to you that same day regarding the draft that he sent you?

A. I don't recall one way or the other.

Q. Dr. Kitz, I'm showing you what's been marked for identification as Plaintiffs' Exhibit 219.

It's DSHS 00062151. Do you see that Dr. Rue is responding to you in response to [29] your sending the draft of your report and saying, "Please see my comments"?

A. Yes.

Q. And whose comments was he referring to?

A. His own.

Q. Dr. Kitz, I'm showing you what's been marked for identification as Plaintiffs' Exhibit 220. Do you recall responding to Mr. Rue regarding your draft report?

A. I did—I don't have an independent recollection, but I see that I did by E-mail.

Q. And you removed your original comments in that draft, correct?

A. Yes.

Q. And you addressed the suggestions and the questions that doctor—that Mr. Rue had?

A. Correct.

Q. Dr. Kitz, I'm showing you what I've marked for identification as Plaintiffs' Exhibit 221, DSHS 00062159.

Do you recall on June 18th—I mean, June 8, 2014 you sending another draft to Mr. Rue about your report?

A. I don't have an independent recollection, but I see that I did.

Q. Do you recall telling Mr. Rue that you had put a "waffly" statement back in about Whole Woman's Health viability as a borrowing customer.

[30] A. Yes.

Q. And you understand that Whole Woman's Health viability as a borrowing customer is in serious question, correct?

A. I don't have—I'm not sure I understand the question.

Q. You understand that Whole Woman's Health as a potential candidate for getting a loan is seriously in doubt, correct?

A. I think the words I used there were worthy of consideration. I don't think they're a slam dunk borrower.

Q. You used "waffly" terms?

A. Uh-huh.

Q. Okay. Does it surprise you that Whole Woman's Health has been rejected by every bank that it's approached in its efforts to purchase a facility that complies with the ASC requirements?

A. I don't have a reaction to that one way or the other.

Q. You refer to, "Presuming Chet chimes in." Who is Chet?

A. Chet Ward, who is the senior partner in a midsize accounting firm in our area who we use to work with some of our surgery centers.

Q. Did you disclose Chet in your report?

A. No.

Q. Did Chet help you write your report?

A. No.

Q. Dr. Kitz, do you recall on June 12th, 2014 sending yet another draft of your report to Mr. Rue?

A. Again, I don't have an independent recollection, but I see [31] that I did.

Q. And do you recall telling Mr. Rue that you were incorporating his suggestions into the report?

A. Again, I don't have an independent recollection, but see that I did say that.

Q. You were incorporating Mr. Rue's suggestions into your report, correct?

A. Yes.

Q. And you see that Mr. Rue responds to you, correct?

A. Yes.

Q. And Mr. Rue says, "I accepted all changes." Do you see that?

A. Yes.

Q. So Mr. Rue is the one accepting the changes, correct?

A. I think in this case he means accepting the changes that when one uses the reviewing mode in Microsoft Word, you can accept the changes.

Q. Dr. Kitz, do you recall that your report contained a critique of Dr. Layne-Farrar's analysis, correct?

A. Yes.

Q. And do you recall that Mr. Rue drafted a version of your report that contained a critique Dr. Layne-Farrar's analysis?

A. No. That is not correct.

Q. Dr. Kitz, if you look on the—on Friday, June 20th, the E-mail on the screen, let's see if this refreshes your [32] recollection about this.

You say, "Vince, I see that 'my'"—and you put it in quotation marks, correct?

A. Yes.

Q. Why did you put that in quotation marks?

A. Because it needed to be my report, and Vince had included something in there that was not something that I had said.

Q. So you say, "'my' report that you returned to me yesterday references my review of an expert report from a Dr. Layne-Farrar," correct?

A. Yes.

Q. And you say, "I've never seen that report."

A. Correct.

Q. And you ask him, "To what does that refer?" Correct?

A. Yes.

Q. So does this refresh your recollection that Mr. Rue had drafted a version of your report that included a critique of Dr. Layne-Farrar's report?

A. I think that's mischaracterizing it. He—in fact, as I recall this very clearly because I was annoyed at Vince, he inserted in one of my drafts in drafting the rebuttal report, that I had reviewed the expert testimony or reports of Mr. Johannes and Dr. Layne-Farrar. There wasn't any substance to anything else about Dr. Layne-Farrar's report, just the appearance of her name there.

[33] Q. And you hadn't reviewed her report?

A. At that time that's correct.

Q. Dr. Kitz, I'm showing you what's been marked for identification as Plaintiffs' Exhibit 224, it's DSHS 00063196.

Do you recall finalizing your report on or about June 26th, 2014?

A. Yes.

Q. And do you recall sending an E-mail to Mr. Rue on that date?

A. Not independently, but I see that I did.

Q. So this refreshes your recollection about that?

A. Yes.

Q. And you tell him that here's my revised report. And you say, "Presuming no further changes," correct?

A. Yes.

Q. So you're telling Mr. Rue, presuming no further changes, you're okay with this in final?

A. Yes.

Q. Now, Dr. Kitz, at your deposition you also testified that Mr. Rue did not make or offer any substantive changes or comments to the positions that you set out in your rebuttal report. Was that true?

A. Yes.

Q. Now, Dr. Kitz, we've just been through a number of E-mails. Now, the primary means of communications between [34] yourself and Dr. Rue was over the phone, correct?

A. Yes.

Q. And at your deposition you testified that you have notes of communications with Mr. Rue, correct?

A. I testified I believe I have some.

Q. Did you turn those notes over to the AG's office?

A. No.

Q. Did they ask for them?

A. No.

MR. LAWRENCE: Your Honor, Plaintiffs would like to move into evidence Plaintiffs' Exhibits 218, 219, 220, 221, 222, 223, and 224.

MS. KANE: Your Honor, we're going to reserve our objection that we've had related to all of these Rue exhibits for the record first.

And then I have a second objection with respect to any E-mails here that don't have a draft attached to them for purposes of completeness. Because that's the entirety of the message, the draft should be attached to the E-mail as well because I see some have the drafts attached and some do not.

MR. LAWRENCE: Your Honor, that's a funny objection because I don't believe that all of the E-mails with the drafts have been produced, so it puts us in a strange position, in that we have not had a collection from the witness and we have looked through the production. I am not aware that we have a [35] copy of each of these documents. We're still investigating that. We had a dump of these documents on us at 3 a.m., I believe it was, on—was it Tuesday morning?

So I would—if the record is not complete, it's because we don't have the E-mail with respect to the draft that was attached by Dr. Kitz. It's not our doing, Your Honor.

MS. KANE: Your Honor, I know at least with respect to Exhibit 218, the first exhibit, the Bates number range, it should show that there was a draft attached to that. And I see that the exhibit being used does not have the draft attached to it.

THE COURT: I am intrigued by the "not our doing" response to the objection. I'm not sure that's been presented to me in any case before since I've been on the bench.

I do not find it to be of major importance. What is clear to the Court is there was an exchange of E-mails between Dr. Kitz and Mr. Rue about the draft of the report. The only report the Court is going to consider is the report that is before me, to the extent I do not sustain an objection to it. Again, I think correspondence between parties who were engaged—

persons who were engaged in drafting a report is relevant testimony for the purpose of trying to impeach the report.

I overrule the objections and Plaintiffs' Exhibits 218, 219, 220, 221, 222, 223, and 224 are admitted, [36] and I will consider that correspondence in determining what weight to give the report.

Q. (BY MR. LAWRENCE) Dr. Kitz, let's talk a little bit about your background, if we could.

A. Okay.

Q. Your background is in the management of medical facilities, correct?

A. Ambulatory surgical centers, at least for the last almost 30 years now.

Q. And you're the principal at a consulting firm called Broshar—

Am I pronouncing that right?

A. Correct.

Q. —Consulting?

A. Yes.

Q. You're not a licensed real estate agent, correct?

A. Correct.

Q. And you've never publish any peer-reviewed papers on cost benefit analysis?

A. Correct.

Q. And you don't have a degree in architecture, do you?

A. No, I do not.

Q. And you've never been a practicing architect, have you?

A. No.

Q. And you don't have a license in any state to prepare [37] architectural plans, do you?

A. No, I do not.

Q. And you've never published anything regarding the construction of ambulatory surgical centers, right?

A. Correct.

Q. And you've never published anything regarding the management of ASCs, right?

A. Correct.

Q. And you've never published anything regarding abortion clinics, right?

A. Correct.

Q. And you've never provided consulting advice to an abortion clinic, correct?

A. Correct.

Q. And you've never advised a bank regarding a lending decision to an ASC; is that right?

A. Correct.

Q. And you've never worked with an abortion provider to obtain financing for the construction of an ASC, right?

A. Correct.

Q. And as we've previously discussed, you submitted an expert rebuttal report in this case, right?

A. Yes.

Q. And that report contained all of your opinions in the case, right?

[38] A. Correct.

Q. And you also, as we've talked about earlier, you submitted written direct testimony in this case; right?

A. Yes.

Q. And that written direct testimony is the same as your rebuttal report?

A. For all intents and purposes, yes.

Q. If you were to run a comparison against them, they would be essentially word for word?

A. Correct.

Q. And you offer no opinions in your written direct testimony that were not in your rebuttal report, right?

A. Can you say that again, please, less the double negative?

Q. Well, they being word for word the same thing, you offer no opinions in your written direct testimony, what's in the binder before you, that was not in your rebuttal report?

A Correct.

Q. And in your direct testimony you have offered no opinion regarding any added expenses that a facility would incur by operating as an ASC as opposed to a licensed abortion clinic?

A. Correct.

Q. And when you prepared your report, you did not consult any sources about the provision of abortion services, right?

A. Correct.

Q. And you didn't consult with an architect, right?

[39] A. Correct.

Q. And you didn't consult with any banks either, right?

A. Correct.

Q. And you didn't consult with any real estate agents either, correct?

A. Correct.

Q. Dr. Kitz, if you'd turn to paragraph 17 of your direct testimony.

A. (Complies)

Q. Are you there, Doctor?

A. Yes.

Q. Thank you. You state, "I agree that substantial renovation would be required for a facility such as WWH-M"—

That's Whole Woman's Health McAllen, correct?

A. Yes.

Q. —"licensed under chapter 139 of the Texas Administration Code to come into compliance with chapter 135 of the Texas Administrative Code." Do you see that?

A. Yes.

Q. And when you're referring to chapter 135 of the Texas Administrative Code, you're talking about the ASC requirement, correct?

A. Yes.

Q. Now, you offer no opinion regarding the extent of renovations that would be required to bring

the El Paso clinic [40] into compliance with the ASC requirements, correct?

A. Yes.

Q. That's a, yes, you offer no opinion?

A. Yes. We have no bananas. Correct.

Q. In performing your analysis, you did not visit the McAllen clinic, right?

A. Correct.

Q. And you didn't visit the El Paso clinic either; is that right?

A. Yes.

Q. Yes, you did not visit?

A. Correct.

Q. You didn't drive by any of those facilities?

A. I did not.

Q. Dr. Kitz, other than coming to trial, have you step foot in the State of Texas in connection with this case?

A. No.

Q. In fact, in preparing your report, you didn't visit a single abortion clinic, did you?

A. No, I did not.

Q. Not even one back in Pennsylvania?

A. Correct.

Q. And you didn't review the architectural plans for either the McAllen clinic or the El Paso clinic, did you?

A. I did not.

[41] Q. And you didn't request that the State defendants serve a request under the federal rules to come and inspect either of those clinics, did you?

A. No, I did not.

Q. And the State defendants didn't offer to get you access into those premises, did they?

A. They did not.

Q. Now, Dr. Kitz, you're familiar with the term "grandfathering" in the context of ASC construction, right?

A. Generally, yes.

Q. And you understand that means allowing an existing facility to adhere to existing construction standards as opposed to the new standards, right?

A. Correct.

Q. And you understand that facilities do not necessarily need to continually upgrade to keep pace with changing regulations, right?

A. Correct.

Q. And you're also familiar with the waiver process from building codes, correct?

A. Only in Pennsylvania.

Q. So you have no knowledge about the waiver process in any of the 49 states other than Pennsylvania?

A. Correct.

Q. Dr. Kitz, you understand that the parties have stipulated [42] in this case that there are 433 licensed ambulatory surgical centers in the State of Texas?

A. I don't—I'm not aware of that stipulation.

Q. Just so you can trust me on this, I'll show you just first that this is a joint stipulation of facts.

A. Okay.

Q. And there in paragraph 6, they would object if I was pulling a fast one.

A. I'm sorry? Say that again.

Q. No. I'm just—you can trust me.

So it says, "There are 433 licensed ambulatory surgical centers in Texas." Do you see that?

A. Yes.

Q. And, of these, 336 are considered to be existing licensed ASCs pursuant to Texas—25 Texas Admin Code, Section 135.51(a). Do you see that?

A. Yes.

Q. So based on that, it's your understanding that more than three in every four ASCs in the State of Texas are considered to be existing licensed ASCs, right?

A. Yes.

Q. And you understand that, as an existing licensed ASC under the administration code, each of these facilities is currently grandfathered and does not have to comply with the construction standards under the administrative code?

[43] A. I don't have an opinion one way or the other.

Q. Do you have an understanding that, as of September 1, 2014, the existing licensed ASCs that provide abortions will no longer be grandfathered?

A. Can you state that again, please?

Q. Do you have an understanding that, as of September 1, 2014, those existing licensed ASCs that provide abortions will no longer be grandfathered?

A. No. I was not aware of that.

Q. Dr. Kitz, if you could turn to paragraph 6 of your direct testimony. In paragraph 6 you claim that, as of May 16, 2014, you understood that there were 58 one-operating room ASCs licensed in the State of Texas, correct?

A. Yes.

Q. Has your understanding changed since May 16, 2014 with respect to that figure?

A. No.

Q. Now, in preparing your report, you had no idea how many of those 58 were existing licensed ASCs as defined in the code, correct?

A. Correct.

Q. And you had no idea how many of those were first license before June 18, 2009, correct?

A. Correct. I didn't look at that information.

Q. Now, you claim in paragraph 6 that two of those facilities [44] are dedicated to carry out abortions, correct?

A. Yes.

Q. And you don't have any information about whether those two facilities are existing licensed ASCs, as defined under the code, correct?

A. Correct.

Q. Now, Dr. Kitz, do you understand that the department does not track the number of individual operating rooms in each ASC?

A. What I think is called—you-all call the DSHS, Department of State Health Services, database, to the best of my recollection, the far right

column of the ASC listing lists the number of O.R., slash, procedure rooms.

Q. Dr. Kitz, I'm showing you what's been marked as Plaintiffs' Exhibit 208. And I'll actually bring a copy to you because it may make it a little bit easier.

A. Okay. Thank you.

Q. Dr. Kitz, do you see this is the State defendants' Second Amended and Supplemental Responses and Objections to Plaintiffs' Interrogatories?

A. Yes.

Q. Dr. Kitz, if you'll turn to page 10 of the document.

A. Okay.

Q. If you'll look at the sentence in the paragraph "responses" under interrogatory number 22. Do you see where it says, "DSHS does not track the number of individual operating [45] rooms in each ASC"?

A. Yes.

Q. Now, Dr. Kitz, in preparing your testimony, you did not review any sources regarding the size and square feet of any ASCs that provide abortions in Texas, right?

A. Correct.

Q. Now, we just talked about testimony that you provided regarding two facilities that you suggest have one O.R.—two abortions facilities, correct?

A. Yes.

Q. Let's talk about the first one. You refer to a Southwestern Women's Surgery Center in Dallas, correct?

A. Yes. That's the second one mentioned.

Q. And you did not inspect the Southwestern Women's Surgery Center before submitting your direct testimony in this case, did you?

A. I did not.

Q. And you didn't review any floor plans of the Southwestern Women's Surgery Center before submitting your direct testimony in this case, did you?

A. I did not.

Q. And you did not speak to anybody at the Southwestern Women's Surgery Center before submitting your direct testimony in this case, did you?

A. I did not.

[46] Q. And you have no information about the square footage of the Southwestern Women's Surgery Center, do you?

A. No, I do not.

Q. And are you aware that ASCs must generally submit construction documents and final plans and specifications in connection with seeking approval as an ASC?

A. Yes.

Q. And do you understand that the State defendants in this case sent a subpoena to Southwestern Women's Surgery Center seeking additional documents regarding that subject?

A. I don't have any knowledge of that.

Q. You understand that the Department of State Health Services is involved in this case, right?

A. I do not have any knowledge of that.

Q. Did you review any construction documents or file plans that had been submitted by Southwestern Women's Surgery Center to the department?

A. I did not.

Q. Did you ask for any of those documents?

A. I did not.

Q. Were you offered any of those documents?

A. I was not.

Q. Now, if the facility does in fact have only one operating room, you have no information about the number of additional treatment rooms in that facility, right?

[47] A. Correct.

Q. And you have no information about the impact of the ASC requirement, what it would have on this facility, come September 1, 2014, if it in fact only has one operating room, do you?

A. Could you restate that, please?

Q. Well, Dr. Kitz, you testified in your deposition about patient flow through a facility, correct? Do you remember that?

A. Yes.

Q. You have no information about what the impact of the ASC requirement would have on this facility come September 1, 2014 with respect to its patient flow?

A. Correct.

Q. Now, you pointed to another facility, the Planned Parenthood for Choice ASC in Houston, right?

A. Correct.

Q. And you didn't inspect that facility either, did you?

A. I did not.

Q. And you didn't review any floor plans for that facility either, did you?

A. I did not.

Q. And you didn't speak to anyone from that facility, either?

A. I did not.

Q. And you have no information about the square footage of [48] that facility either, do you?

A. I do not.

Q. And you didn't ask the department for any architectural plans for that facility either?

A. I did not.

Q. And none of those architectural plans were offered to you either, were they?

A. They were not.

Q. And you have no information about the number of treatment rooms that facility may have, do you?

A. I do not.

Q. And you have no information about what the impact of the ASC requirement will have on the patient flow at that facility once it goes into effect, do you?

A. I do not.

Q. Dr. Kitz, in preparing your report, you didn't research the time that it takes to perform an abortion, did you?

A. I did not.

Q. And you didn't research the time it takes to prepare an operating room for a surgical abortion patient, did you?

A. I did not.

Q. And you—you performed no research whether a single physician could perform more abortions in a day in a two-operating facility as opposed to a one-operating room facility, did you?

[49] A. I did not.

Q. Now, Dr. Kitz, you're familiar with the guidelines for design and construction of hospitals and outpatient facilities published by the Facilities Guidelines Institute?

A. I have more than a walking knowledge of them, yes, and only the ambulatory surgery center section.

Q. And you understand that the guidelines apply to new construction and major renovations, correct?

A. Correct.

Q. And you understand that those guidelines do not apply to existing facilities, correct?

A. The new—for example, there are 2014 guidelines that currently are available. They do not apply to surgery centers that were established in 2011.

Q. And you understand that compliance with the FGI guidelines doesn't necessarily equate with requirements—with requirements of the Texas ASC requirement, correct?

A. Correct. If you go word for word, yes.

Q. Now, Dr. Kitz, you offer an opinion that ASC could be constructed within 3,000 square feet, right?

A. Yes. A one-O.R. ASC.

Q. And one of the things you rely on is a paper entitled *Freestanding and Outpatient Surgery Facilities* that you took from the Web site of the American Society of Anesthesiologists, correct?

[50] A. Yes.

Q. And you have not spoken to any of the authors of that paper about that paper, have you?

A. I have not.

Q. And that Internet paper, it does not discuss the Texas ASC requirements, right?

A. Correct.

Q. And it does not discuss abortion clinics either, does it?

A. It does not.

Q. Now, if you could turn to paragraph 23 of your direct testimony.

A. I don't have the draft testimony.

Q. No, no. Paragraph 23 of your direct testimony. I'm sorry if I was unclear.

A. Yes.

Q. If you'll take a look at the last sentence, you state, "The ASA"—what is the ASA?

A. American Society of Anesthesiologists.

Q. —"also states that a minimum of 3,000 square feet is needed to accommodate each O.R., paren, the O.R. itself along with support space." Do you see that?

A. Yes.

THE COURT: The last one that was admitted was 224.

MR. LAWRENCE: Okay. 225. Thank you, Your Honor.

Q. (BY MR. LAWRENCE) Dr. Kitz, do you recognize Exhibit 225 [51] as the paper from the American Society of Anesthesiologists that you relied on?

A. Yes. It seems to be, yes.

Q. If you'll turn to paragraph 76—I mean, page 76. Sorry I misspoke.

A. (Complies)

Q. If you'll look at the middle of the paragraph, you see where it says, "In general, approximately

3,000 square feet of surgery center space is needed for each O.R.'"?

A. Yes.

Q. Now, you didn't speak to any of the authors about what they mean by "surgery center space," did you?

A. No.

Q. You didn't ask them whether that includes a waiting room, did you?

A. I did not.

Q. And you didn't ask them whether that includes waiting room bathrooms, did you?

A. I did not.

Q. And you didn't ask them whether that includes any administrative offices, did you?

A. I did not.

Q. You did not ask them whether that includes doctors' offices, did you?

A. I did not.

[52] Q. And you didn't ask them whether that includes any ultrasound rooms, did you?

A. I did not.

Q. And you didn't ask them whether that includes any counseling rooms, did you?

A. I did not.

Q. And you didn't follow up with any of the authors about what they meant by this, did you?

A. Correct.

Q. Dr. Kitz, if you could turn to paragraph 25 of your direct testimony.

A. Yes.

Q. You refer to reconstruction data that sets forth a $302 per square foot construction estimate, right?

A. Yes.

Q. And this is data that you obtained from a Web site, right?

A. Correct.

Q. I'm showing you what's been marked as Plaintiffs' Exhibit 226. Is this the data that you obtained from the Web Site?

A. Yes.

Q. Now, you don't use this data in your work for your consulting company, right?

A. Correct.

Q. And at your deposition you had no opinion regarding [53] whether it was a reliable source, right?

A. Correct.

Q. And you had no idea how the construction arrived at the estimate and data you relied on, right?

A. Correct.

Q. And you have no idea whether this figure includes all of the soft costs that Mr. Johannes testified about in his direct testimony?

A. Tell me what you mean by "soft costs."

Q. Well, you read Dr. Johannes's report, correct?

A. Yes.

Q. And you recall that he had constructions costs, and on top of that he had soft costs. Do you recall that?

A. Vaguely, but I don't remember what was in there.

Q. That's the report that you filed the rebuttal report to, correct?

A. Yes.

Q. Now, the data refers to a facility in McKinney, Texas, correct?

A. Yes.

Q. And you've never visited this facility?

A. Correct.

Q. And you never spoke to anyone from Reed Construction in preparing your report, correct?

A. Correct.

[54] Q. Now, the total building costs per square foot in this—in this Internet data is $301.52, right?

A. Yes.

Q. And it says that for this facility, that the total building cost is $3,769,000, right?

A. Yes.

Q. Now, I don't have a calculator with me. But if I represent to you that that's—that would mean 1200—12,500 square feet. We could get one for you if you want to do the math yourself?

A. That's okay. I'll take your word for it.

Q. Now, if you—you've heard the term "economies of scale," right?

A. Yes.

Q. Okay. And you understand that, all things being equal, that if you build a bigger building, it will be less per square foot, correct?

A. Not necessarily when it comes to health care.

Q. You disagree with Mr. Johannes on that?

A. When it comes to surgical centers, I do.

Q. What about just for the build-out of the building, without any of the equipment?

A. I still don't agree with the statement.

Q. Okay. Dr. Kitz, in paragraph 25 of your direct testimony, you refer to design cost data that includes a $199 a square [55] foot fit-out construction cost estimate; is that correct?

A. Yes.

Q. And, Dr. Kitz, I went to the Web site that you cite in your direct testimony and downloaded this last night. It's a one-page sheet from the Internet. This is what you're relying on?

A. Yes.

Q. And I'll hand up a copy to you as well.

And, again, you've never used this data in connection with your work for your own consulting company, correct?

A. Correct.

Q. And you can't attest to the reliability of this data either, can you?

A. I cannot.

Q. And you never spoke to anyone from Design Cost Data about this information in preparing your report did you?

A. I did not.

Q. You just went to the Internet and pulled it down, correct?

A. Correct. I was looking to get some resources that confirm numbers that we're very certain of that we routinely use in our consulting firm.

Q. Now, with respect to the fit-out figure that you're referring to, that's down here in the—in the lower right-hand corner where it says, "Surgery center buildings, ambulatory surgery center." Correct?

[56] A. Yes.

Q. Now a fit-out is different from building from the ground up, correct?

A. Yes.

Q. With a fit-out there's—there's an existing building shell, and then the—you just occupy it and build out within that shell, correct?

A. Shell and utilities in our experience are at the building.

Q. Now, that building shell is not free, correct?

A. Correct.

Q. It costs something to build that shell, right?

A. Sure.

Q. And it would cost something to buy that shell as well if you wanted to buy it?

A. Correct.

Q. And it would cost something to lease that shell if you wanted to lease it, correct?

A. Correct.

Q. Now, we talked earlier about the soft costs that were in Mr. Johannes's report, correct?

A. Yes.

Q. And not remembering what those soft costs were exactly, you couldn't tell me whether this 198 figure includes all the soft costs, correct?

A. Correct.

[57] Q. Now, Dr. Kitz, in paragraph 22 of your direct testimony you refer to a Trinity Surgery Center in San Antonio as being a 6,500 square foot facility with two operating rooms, correct?

A. Yes. Two operating rooms and two treatment rooms.

Q. And two treatment rooms.

You've never visited that facility either, have you?

A. I have not.

Q. And you've never reviewed any architectural plans for that facility, have you?

A. I have not.

Q. And you simply got that square footage and other information about the facility from a Web site, correct?

A. Yes.

Q. And when you prepared your report, you had no other basis other than that information you received from the Web site for the basis of your opinion about that facility, correct?

A. Correct.

Q. And you had no idea of whether it was an existing facility under the code and thus exempt from the construction requirements, right?

A. It had to meet with the—whatever construction requirements were in place at the time it was established.

Q. Do you know what construction requirements were in place prior to 2009 for ASCs in the State of Texas?

A. No.

[58] Q. Dr. Kitz, you have no opinion as to how someone would consider the possibility of additional restrictions on abortion facilities in the State of Texas when making a decision about whether to loan money to an abortion facility, do you?

A. I do not.

Q. And you don't know whether a lender would consider a risk to its public image in making a decision about lending money to an abortion facility, do you?

A. I do not.

MR. LAWRENCE: Your Honor, the plaintiffs move for the admission of Exhibits 225, 226, and 227, the Internet data that Dr. Kitz relies on.

MS. KANE: No objection.

THE COURT: Plaintiffs Exhibits 225, 226, and 227 are admitted.

At this time we'll take our morning recess. It's a good point to break. We'll be in recess until 10:45.

(Recess)

(Open Court)

THE COURT: Ms. Kane, redirect?

MS. KANE: Thank you, Your Honor.

REDIRECT EXAMINATION

BY MS. KANE:

Q. Dr. Kitz, you had some discussions with Plaintiffs' counsel regarding your E-mails with Dr. Rue, correct?

[59] A. Yes.

Q. Okay. Can you tell me, so who drafted the initial version of your report?

A. I did.

Q. Did Dr. Rue at any time do any major, or as you call them, substantive, edits to the draft after you provided him with your initial draft?

A. No.

Q. Okay. Is there anything in your testimony that you submitted to this Court that you consider to have been drafted by Dr. Rue that you then just adopted as your own opinion?

A. No.

Q. Okay. Now, there was a mention of somebody name Chet. Can you explain what Chet did to help you in this case, if anything?

A. Yes. He put together the consolidated balance sheet to which I refer.

Q. Okay. Did you—can you explain briefly what that means and hopefully in an uncomplicated way, if possible?

A. Yes. It is—it was taking the balance sheet information from all the entities about which we were provided information and, if you will, mushing it together.

Q. Okay. Is that work you could have done yourself?

A. Yes.

Q. Why did you not do it yourself?

[60] A. It was more expeditious to have him do it, and we had such an abbreviated time frame that he helped out in that way.

Q. Did he manipulate numbers in any way?

A. No.

Q. Do you consider him putting everything into a consolidated balance sheet to be substantive in any way?

A. No.

Q. Did his doing—doing that task affect your opinion in any way?

A. No.

Q. Now, there was also mention of an E-mail in which you, I guess for lack of a better word, chastised Dr. Rue for including a reference to Dr. Layne-Farrar in a draft report. Do you recall that discussion?

A. Yes.

Q. Do you recall what text was in the draft that you wished for him not to have put in.

A. I don't remember the exact words, but I'll be close. One of the initial paragraphs said something like, "In preparing this report, I reviewed the expert reports over Mr. Johannes and Dr. Layne-Farrar."

Q. So other than a statement that you had reviewed those reports which you had not yet done to that time; is that correct?

A. I had reviewed Mr. Johannes's, but not Dr. Layne-Farrar's.

[61] Q. So other than the statement that you've reviewed their reports, was there anything else in the draft that Mr.—excuse me—Dr. Rue sent back to you regarding an opinion about those reports?

A. Not to the best of my recollection.

Q. Okay. So there is some language in your—the testimony you submitted to this Court regarding your opinions related to Mr. Johannes and Dr. Layne-Farrar's reports; is that correct?

A. Yes.

Q. And who drafted that language?

A. I did.

Q. Okay. Did Dr. Rue at any time offer you any draft language regarding an opinion related to those two individuals to include in your report?

A. He offered from time to time what I would call editorial suggestions, but nothing that influenced the opinions.

Q. Okay. Thank you. So is it correct that you reviewed both Mr. Johannes' and Dr. Layne-Farrar's reports?

A. Yes.

Q. Okay. Now, can you tell me in a concise way, if possible, do you—what kind of work do you do for individuals who want to either build or start an ASC?

A. It's highly variable. But in some cases we do feasibility studies, which include projections of fit-out and equipment expenses. We provide operational consulting for surgery [62] centers, and we help surgery centers to get licensed and accredited. And those are both terms of art, if you will.

Q. So if somebody wanted to open an ASC, could they come to you and ask you how much it might cost to do so?

A. Yes.

Q. Is that something you do in the normal course of your business?

A. Every day almost.

Q. If you had to estimate, how many times have you completed that task?

A. Five dozen.

Q. And if you could briefly describe, if somebody comes to you and asks you, I want to open up an ASC, in a very global sense, what do you do in order to provide them with information regarding what it might possibly cost to do so?

A. Look at the number of anticipated cases, the number of anticipated procedures, which are two separate things, the types of procedures. We look at—then we compute square footage that's necessary or

the number of operating rooms in the anticipated square footage. We make estimates about fit-out expenses, equipment costs. And those become part of an income—or feed information into an income statement that we develop.

Q. Okay. So in doing—in that process, was that—the process that you do for your clients in determining costs for [63] opening up an ASC, was that similar or different to the process you engaged in here with respect to looking at the costs for potentially opening up an ASC in this case?

A. The first part of it is very similar, in that what does it cost to—for the "bricks and sticks," if you will, is the term of art, as well as the equipment. And that's very analogous to what we did here. The income statement part of it is not something we were asked to do here.

Q. So but the initial part is something that you do in the regular course of your business in terms of coming up with the initial cost of an ASC?

A. Just about every day, yes.

Q. And with respect to—excuse me. Strike that.

Now, there was a question in this case, you offered an opinion based on an assumption that the McAllen facility at issue here could open up a one-O.R. ASC; is that correct?

A. Yes.

Q. And why did you assume a one-O.R. ASC for purposes of your analysis?

A. It was based on the annualized number of abortions that we had computed. I'm sorry. The annualized number of abortions that we had computed based upon, I believe it was, nine months worth of information from Whole Woman's Health.

Q. Okay. So you received data regarding essentially how many procedures the facility at issue had actually performed during [64] a nine-month period?

A. That's correct.

Q. And then if I'm hearing you correctly, you computed out what that would then look like in terms of a 12-month period?

A. Correct.

Q. And then you came up with a number in what range, if you recall?

A. I believe it's in my report. If you're asking me from memory, I believe it's 1500 and change.

Q. Okay. And you—you had also testified that a one-O.R. facility could accept about how many—or complete about how many procedures per year?

A. Well, my testimony is that the number—what the number one use is for planning purposes, not the number that can be completed. The number that can be completed in our experience typically is much greater than that. So for planning purposes, in

our experience, you look at a number or use a number between 1,000 and 1800, depending upon the types of cases and, more importantly, the duration of those cases.

Q. And so when you estimated a one-O.R. ASC in this case, is that process that you engaged in to come to the conclusion that a one-O.R. ASC would be sufficient similar to what you do for your existing clients in planning purposes for an ASC?

A. Exactly the same.

Q. And are you aware of whether or not the regulations that [65] are at issue here allow for a one-O.R. ASC?

A. I believe they do.

Q. Okay. And there had been some discussion with Plaintiffs' counsel regarding some documents you reviewed to determine whether or not one-O.R. or one-procedure room ASCs might be allowed in Texas for facilities that perform abortions. Do you recall that?

A. Yes.

Q. Okay. And can you explain—and there's testimony in your written direct testimony regarding that; is that correct?

A. I'm sorry. I lost you.

Q. You testify in your written direct regarding reviewing certain documents related to whether or

not there are one-O.R. ASCs performing abortions in Texas; is that correct?

A. Yes.

Q. Do you recall what you reviewed in order to come to that determination?

A. The DSHS database and some other Web information, I believe.

Q. And do you recall what you reviewed on the DSHS database in order do determine whether or not there were one-O.R. ASCs or one-procedure room ASCs that performed abortions?

A. Yes. The DSHS Web site provides a listing of the 400-plus surgery centers and includes information like the name of the facility, the number of O.R.s and/or procedure rooms, the [66] types—sometimes the specialty and sometimes more specific information about procedures carried out in those facilities, as well as additional information.

Q. Now, are you—in your own practice, do any of the facilities that you consult for operate as one-O.R. ASCs?

A. Yes.

Q. Is it unusual to have a one-O.R. ASC?

A. No.

Q. Okay. Now, there was discussion regarding certain Internet information that you used for your cost estimates. Do you recall that?

A. Yes.

Q. Other than that Internet information, were there any other kind of financial data points you used in coming up with your analysis that you offer in this case?

A. Our experience.

Q. And can you explain to me what you mean by your experience with respect to cost analysis?

A. Sure. So the 195 square foot fit-out expense information is a number that we've used really since the financial crisis hit. So for about six or seven years now, and it's a number that has proved true time and time again.

Q. So when you say the 195, is that per-cost per square foot?

A. Yes. For fit-out.

[67] Q. And that's a number you use in your business?

A. Yes.

Q. Okay. And that's a number you use currently if you had a client coming to you and asking about costs for building out an ASC?

A. Yes.

Q. Okay. And so if– because—do you use any other number for your—for your own clients with respect to estimating costs for ASCs on a square foot basis?

A. We would bump that number up if it were going to be a union construction job. It's probably about $215 a square foot.

Q. So if you—had that number available to you, why did you refer to other information from the Internet in coming up with your analysis in this case?

A. I just felt for purposes of the report, I needed to be able to point to something that was at—either at or, you know, close to our number to sort of verify, if you will, the number that we have come to use.

Q. And if a client was coming to you asking you to personally advise them in your own business about the costs of building out an ASC, would you feel confident in using the 195 number that you typically use?

A. Yes.

Q. You mentioned that you didn't necessarily agree that, as [68] an ASC increases in square footage size, that the cost per square foot would necessarily go down. Can you explain a little bit as to your basis for that belief?

A. Sure. The cost of constructing a surgery center, when we're talking about fit-out expenses, involve a lot of specialty items—medical gas piping

that goes in behind the walls, the medical gas systems themselves, the air handling, otherwise called the HVAC systems, things like that. And it is not necessarily true that—in our experience, that the per square footage cost decreases when you have a larger facility because you still need to put medical gas piping in a 10,000-foot facility just like you do in a 3,000-square-foot facility.

MS. KANE: Thank you, Dr. Kitz.

MR. LAWRENCE: I just have a few questions.

THE COURT: You may proceed.

RECROSS-EXAMINATION

BY MR. LAWRENCE:

Q. Dr. Kitz, you just referred to—spoke a little bit about Chet on your redirect. Is Chet an accountant?

A. Yes, he is.

Q. Do you recall during your deposition when we asked whether you had consulted an accountant in connection with your work?

A. Yes.

Q. And you responded no?

[69] A. Correct.

Q. Now, Dr. Kitz, you were speaking on redirect about how this work that you did in connection with your report, is it similar to your work for Broshar Consulting?

A. Correct.

Q. In your work for Broshar Consulting, you don't consult the Reed Construction Data, correct?

A. Correct.

Q. And you don't consult the other Internet data that you pointed to in your report, correct?

A. Correct.

Q. Now, Dr. Kitz, you recall during your redirect you talked about relying on some information you found regarding the number of O.R.s at facilities in Texas—ASC facilities?

A. Yes.

Q. And you recall that we looked at this sworn interrogatory from the defendants in this case that states that DSHS—DSHS does not track the number of individual operating rooms in each ASC. Do you see that?

A. Yes, I do.

Q. Dr. Kitz, do you recall during your deposition that we asked you whether you had any standard

figure that you provided to clients with respect to the costs of new ASC construction?

A. I don't recall one way or the other.

Q. Do you recall we asked you, "Does Broshar Consulting have [70] a figure for new construction that is sort of your go-to number just like the 195 is for construction within an existing shell?"

A. Now, that I see it, yes.

Q. And you responded no?

A. Correct.

Q. And we asked, "Why Not?"

A. Yes.

Q. And you said, "Because we don't have enough experience with that"?

A. Correct.

MR. LAWRENCE: Your Honor, plaintiffs have no further questions.

THE COURT: Ms. Kane, further redirect?

FURTHER DIRECT EXAMINATION

BY MS. KANE:

Q. Just briefly, Your Honor. Dr. Kitz, I want to show you—and it's going to be a little bit difficult to read. I'm going to represent that this is part of your deposition transcript. And when you were asked—

A. I'm going to get seasick.

Q. I'm sorry. I don't want to make you seasick.

When you were asked whether or not you consulted an accountant, do you know specifically what that was in reference to?

[71] A. I don't recall.

Q. Okay. If I show you your deposition, I'll show—we can see here we're on page 76. And do you see the question that was relayed to you by Plaintiffs' counsel?

A. Yes.

Q. I'm now going to turn to page 75. If you see we're on page 75, and I apologize for

THE COURT: We're just all getting seasick.

MS. KANE: I apologize, Your Honor. We should all take Dramamine before trial.

Q. (BY MS. KANE) And on line 17 you see that they're asking you about a reference to RAPA transfers. Do you see that?

A. I do.

Q. Okay. And is that—they're asking you what that term meant. Do you see that?

A. I do.

Q. And then they ask what you did to figure out what that term meant?

A. Yes.

Q. And then they ask you—and you say, "I Googled it." You see that?

A. I do.

Q. And so when they're asking you, "Did you consult an accountant?" would it be fair to say they were asking you whether or not you consulted an accountant with respect to the [72] term "RAPA transfers"?

A. Yes.

Q. And, again, did Chet, who is an accountant, have any influence on your opinions in this case or offer any opinions of his own that you included in your report?

A. He did not.

Q. Thank you.

MS. KANE: No further questions.

THE COURT: Mr. Lawrence?

MR. LAWRENCE: No further questions, Your Honor, other than to renew our objection on *Daubert* grounds.

THE COURT: All right. The objection is overruled. The witness may step down.

MR. BLACKLOCK: Your Honor, we had discussed previously that the plaintiffs might want to

call an expert at this point during our case and that we would agree to that. I believe we've discussed it and this would be the appropriate time.

MS. TOTI: Right, Your Honor. The plaintiffs would like to call Mari Robinson to the stand.

THE COURT: All right.

MS. TOTI: She's the Director of the Texas Medical Board.

THE COURT: You may do so. Thank you, Mr. Blacklock, Ms. Toti.

[73] (Witness sworn)

MARI ROBINSON,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. TOTI:

Q. Good morning. Could you please state your full name for the record.

A. Mari Robinson. It's M-a-r-i R-o-b-i-n-s-o-n.

Q. And what is your current employment position?

A. I'm the Executive Director of the Texas Medical Board.

Q. And you're a defendant in this case; is that correct?

A. Yes.

Q. In your official capacity?

A. In my official capacity, yes.

Q. Okay. So in front of you I have placed Plaintiffs' Trial Exhibits. They're in the white binders. Can I ask you to—actually, the first exhibit I want to show you isn't in those binders.

Okay. Can I ask you to take a look at what's been marked as Plaintiffs' Exhibit 208.

A. I'm sorry. Is there somewhere specific I need to look?

Q. First I just want to ask you if you are familiar with this document.

A. I know that you have served lots of discovery requests. So if this is one that we responded to, then, yes, I would have [74] read it at that time.

Q. Okay. I would like to direct your attention to page 5 of this document.

A. Okay.

Q. Actually, page 8 of the document, interrogatory number 18.

A. Okay.

Q. Okay. And so just to be clear on the record, this is the State Defendants' Second Amended and Supplemental Responses and Objections to Plaintiffs' Interrogatories; is that correct?

A. That's what the title says.

Q. Okay. So for interrogatory number 18, it asks the medical board to identify instances during the past five years when it's investigated a physician for, quote, failure to practice in an acceptable and professional manner consistent with public health and welfare, as that phrase is used in 22 Texas Administrative Code, Section 190.8, Subsection 1. Is that correct?

A. That is what this says.

Q. Okay. And in response the State defendants identify a document. It's described as a document produced as Deposition Exhibit 9 from the Texas Medical Board's 30(b)(6) deposition on July 23rd, 2004 and also listed as Plaintiffs' Trial Exhibit 206 on Plaintiffs' exhibit list.

Ms. Robinson, you were the deponent at the Texas Medical Board's 30(b)(6) deposition; is that correct?

[75] A. Yes.

Q. And so you are familiar with this document that's been identified as Plaintiffs' Trial Exhibit Number 206; is that correct?

A. I don't have it in front of me.

Q. But you are familiar with the document, correct?

A. Well, I don't know what was identified as Exhibit 206.

Q. I can give you—at the deposition of the Texas Medical Board, did you produce a spreadsheet that hadn't been previously produced to the plaintiffs in response to their discovery requests?

A. I believe we produced three.

Q. And what were those spreadsheets? Can you can describe them, please?

A. They were inquiries that were run through our database trying to use what we believe were appropriate search terms.

Q. And so can you—can you tell me for each of the three spreadsheets what information they contained?

A. Not off the top of my head.

Q. Can you give it a shot, since you're here under oath pursuant to a subpoena?

A. Okay. Well, I don't have it in front of me, but I can tell you that I think there was probably a name, a description of the complaint. If the search term that we entered was in there, it may have had a date. I don't—I don't know. I [76] know that we queried the information and attempted to get the information related to the complaints, but there's a lot of information in the database. So I—without this the

spreadsheet before me, I can't tell you every column that was on it.

Q. The spreadsheet has over 50,000 entries; is that correct that?

A. That sounds approximately right.

Q. And it's about 1500 pages?

A. That sounds about right.

Q. So can you—can you tell me a bit about the database from which this spreadsheet was exported?

A. Sure. The Medical Board maintains a database of the complaints that it receives with certain aspects of information about those complaints.

Q. And when you say certain information, what information are you referring to?

A. Well, it depends on what part of the process it was resolved. But, in general, the name of the physician is going to be there, the very initial allegations may be there. It depends on if it was jurisdictional or not. The name of the complainant will likely be there, and the contact information for the physician will be there. If there was some for the plaintiff, for the plaintiff. It's assigned a tracking number and the date that we received it. And then depending how far [77] it went, it may have additional information like allegations. It may have an assigned investigator. It may have resolution date. There's lot of other things that it could have.

Q. And you do recollect producing a spreadsheet with over 50,000 entries at the Texas Medical Board's deposition, correct?

A. That sounds approximately right, yes.

Q. And what is your—did you play any role in the creation of that spreadsheet?

A. Other than discussing very generally with my general counsel the creation of it, it was done by the information technology group.

Q. And what is your understanding of the information that was contained in the spreadsheet?

A. I don't know what you mean.

Q. What information was in this spreadsheet that you produced as the corporate representative of the Texas Medical Board at the 30(b)(6) deposition?

A. And as I said, I don't remember all the columns. I think the name was on it. If there were general allegations, they were there. Probably the date we received it. But without at least a front page in front of me, I can't tell you every single column that we included.

Q. To—it's my understanding that, at your request, your counsel asked us not to produce the spreadsheet here in court [78] or show it on the screen because it contained confidential information. But are you now saying, without having the spreadsheet in front of you here in court, you're not able to provide any information about it?

A. Well, if you can show me the top columns without any of the confidential information, I can tell you the columns that were provided. That would just be the information type without giving any confidential information. But the names themselves, no, I did memorize all 50,000. And those are the confidential pieces of information and what they're attached to.

Q. Sure. That's fine. I think perhaps you didn't understand my question. What I would like to know is, generally, what information did you export to the spreadsheet from the database? Is it all of the data contained in the database or is it a specific subset of data?

A. I would estimate that it is probably a specific subset of data. The database is very, very large.

Q. And what is the subset of data that was contained in the spreadsheet?

A. And what I'm trying to say is I'm—the name was on there, the allegations were on there, probably the date was on there. I'm not sure how much more would have been on there other than the basic allegations, the name, the date, and potentially the case identifier, and maybe a resolution code.

Q. All right. I'm going to show you what's been marked as [79] Plaintiffs' Exhibit 26. Actually, I think you have Plaintiffs' Exhibit 26 in one of those binders.

A. Okay.

Q. Does Plaintiffs' Exhibit 26 help to refresh your recollection about the information contained in the spreadsheets the Texas Medical Board produced during its 30(b)(6) deposition?

A. Sure.

Q. And so can you tell me a little bit more about the information that is represented in this spreadsheet?

A. Well, so it's basically the information I already told you. It's the physician's first name and last name, so the name; the identifying case numbers, which I had said; the date that we received it, which I had said; the allegations, which I had said, including the summary related to it. If the—the status is on here and the date that the status was assigned, if it was filed or not, and the resolution information, if there is any.

Q. Okay. And you said that you produced three different spreadsheets at the deposition; is that correct?

A. That's what I remember.

Q. What distinguished the information produced in those three spreadsheets? How are they different from one another?

A. The search terminology that we used.

Q. Okay. Can you tell me about the search terminology?

[80] A. Sure. On the different requests that you made, one was for a very broad category, the one you have identified today, which was public health and welfare practicing consistent with public health and welfare. The second related more to patient abandonment. And the third related to abortion services. So we ran different search groups within those three types to try to produce those spreadsheets.

Q. And so the large spreadsheet, the one with the voluminous entries, what is your understanding of the universe of information that was captured in that spreadsheet?

A. It's a—during the time period identified, it's the groups that dealt with practice—the complaints that dealt with practice inconsistent with public health and welfare that we could identify.

Q. Okay. And so to the best of your recollection, you were able through that spreadsheet to identified over 50,000 instances of physicians engaged in practice that posed a threat to public health and welfare; is that right?

A. No. It's the complaints we received alleging that happened. Not all of them would have borne that out.

Q. Okay. And how long have you been executive director of the Texas Medical Board?

A. Around five or six years now.

Q. And how long have you worked at the Medical Board overall?

A. Since 2001.

[81] Q. And you've held various positions at the Medical Board; is that correct?

A. Yes.

Q. Including as an investigator?

A. No.

Q. What are the positions that you've held at the Medical Board?

A. I was litigator, I was the manager of investigations, I was the manager of investigations complaints, manager of compliance added to that group, the enforcement director, and, ultimately, the executive director.

Q. So it would be fair to say that you have a lot of experience with the investigative and enforcement practices at the Texas Medical Board, correct?

A. Yes.

Q. In your experience, typically, what percentage of complaints are substantiated?

A. Generally we start with around—well, at the end of the day, probably about—somewhere between 5 and 10 percent.

Q. So if the spreadsheet contains over 50,000 entries, we're still talking about quite a large university—you know, 5 or 10 percent of 50,000, we're still talking about thousands of instances of physicians engaged in conduct that's inconsistent with the public health and welfare. Is that fair to say?

[82] A. Yes.

Q. How many of those instances identified in the spreadsheet were conducted by abortion providers?

A. I don't know.

Q. Why don't you know?

A. Because we don't ask someone to identify whether they are an abortion provider or not to be licensed in our state.

Q. Is all of the information in the spreadsheet true and accurate?

A. To the best of my knowledge.

Q. So if I were to look at the spreadsheet with knowledge of who is a physician that provides abortion services in Texas, I would be able to make that determination based on the information on the spreadsheet?

A. Maybe. You would be able to tell whether the complaints we were able to identify using the search terms you gave resulted in a complaint against a list of providers that you had. But we don't track exactly

by the search terms that you gave, so there may be a few other complaints out there that weren't covered by this universe.

Q. Okay. But you have no reason to think that any of information contained in the spreadsheet is not accurate?

A. I don't have any reason to believe that it's inaccurate, no.

Q. And so if you take a look at Interrogatory 19 and the [83] response to Interrogatory 19, which is on page 9 of Plaintiffs' 208, that one requests information about—

Well, let me ask you first: Are you aware that the Texas Medical Board has authority under 22 Texas Administrative Code, Section 190.8, Subsection 1, Subsection F, to investigate physicians for failure to timely respond in person when on call or requested by emergency room or hospital staff?

A. Yes.

Q. How often does the Texas Medical Board receive complaints for failure to respond when requested by emergency room or hospital staff?

A. I don't have a definite number for you.

Q. Are you aware of any instances in which the Texas Medical Board has investigated an abortion provider for engaging in this conduct?

A. I'm not aware of any that specifically relate to being on call, but I know that we have a few cases that we've investigated in relation to abortion.

Q. And those are all of alleged violations of House Bill 2, correct?

A. No.

Q. What instances of an investigation of an abortion provider can you recall that predate the enactment of Texas House Bill 2?

A. I believe we provided you with a spreadsheet of [84] approximately 45 names. I believe only a handful of those related to House Bill 2.

Q. And of those 45 names—I mean, I'm not actually sure about whether you provided the spreadsheet or not. But of the 45 names that you are thinking of, how many of those resulted in some kind of disciplinary action against a physician for conduct that predated Texas House Bill 2?

A. The one—I'm aware of one that specifically related to disclosures and HIPAA—potential HIPAA violations and disclosures to the patients. That's one that I'm for sure aware of. I don't recall any disciplinary action taken in relation to on call problems related to an abortion provider.

Q. So how many years overall did you say you spent at the Texas Medical Board?

A. I have been there since 2001.

Q. Since 2001. And since 2001 you can recall a grand total of one instance in which disciplinary action has been taken against an abortion provider, and that disciplinary action was related to informed consent and HIPAA violations; is that correct?

A. Well, since 2001 I haven't been tracking abortion provider orders, but the only one that I can recall—

Q. I'm asking about your personal knowledge.

THE COURT: Let her finish.

A. —but the only one that I can recall right now not [85] related to House Bill 2 is the one I just identified.

Q. Okay. And so in response to the plaintiffs' interrogatory, the Texas Medical Board wasn't able to identify any instances of an abortion provider failing to respond to a request by emergency room or hospital staff; is that correct?

A. I'm not aware of any instance where we have taken an action on that, no.

Q. Okay. So to the extent that Defendants are making contentions in this lawsuit about alleged patient abandonment by abortion providers at hospital emergency rooms, the defendants can't rely on any information from the Texas Medical Board to substantiate those allegations; is that correct?

A. The Medical Board has not taken an action for such an allegation that I am aware of.

Q. The Medical Board had no relevant information that it could point to in response to the plaintiffs' interrogatory about this issue; is that correct?

A. I don't know if it's relevant or not. We gave you ultimately the spreadsheet. But I'm not aware of the Texas Medical Board taking an action for those allegations.

Q. But the spreadsheet couldn't identify any individuals that were disciplined for—specifically for failure to timely respond in person when on call or requested by emergency room or hospital staff, as that phrase is used in 22 Texas Administrative Code, Section 190.8, Subsection 1, Subsection F; [86] is that correct?

A. Right. I have no recollection of the Medical Board taking an action for that purpose.

Q. But in response to the interrogatories, it wouldn't just be your personal recollection, correct? It would be the entire body of knowledge that's available to the Texas Medical Board, correct?

A. Based on the query that we ran, yes. I cannot tell you for sure that every single complaint would have been identified. But based on the query we ran on the information you asked for, I'm not aware of anything being on that spreadsheet and I'm not aware of the Board taking that action.

Q. And, Ms. Robinson, you're an attorney; is that correct?

A. Yes.

Q. And so you're aware of the obligations that are imposed on parties to litigation under Rules 26 and 37 of the Federal Rules of Civil Procedure; is that correct?

A. Yes.

Q. Okay. I'd like to ask you to take a look at Plaintiffs' Exhibit 33, which is in one of those binders—I think in the large white binder in front of you. It's another set of responses to interrogatories?

A. Number 33?

Q. Yeah. Number 33?

A. This starts with 65.

[87] Q. All right. Well, you can have my copy with the underline.

So in Plaintiffs' Exhibit 33, which are Defendants' responses to interrogatories served by the plaintiff, interrogatory number 20 asks the defendants to identify any threats to public health or welfare occurring at a licensed abortion facility that could not be adequately addressed through existing regulation. And in response to that interrogatory, the Texas Medical Board provided no information; is that correct?

A. We don't license abortion facilities, so no.

Q. But you regulate physicians that engage in conduct occurring at licensed abortion facilities; is that correct?

A. I'm not aware of any instance that we have related to a licensed abortion facility.

Q. So you cannot identify any instances of physicians practicing at licensed abortion facilities that engaged in threats to public health or welfare that couldn't be adequately addressed by existing regulation; is that correct?

A. We don't license those facilities. I am unaware of anything for which you're putting forth.

Q. Okay. So to the extent that the defendants in this case are making contentions that, prior to the enactment of House Bill 2, existing laws were insufficient to maintain patient health and safety at abortion facilities, the Texas Medical Board can't provide any information to substantiate that—[88] that contention. Would that be fair?

A. We do not oversee that, so no.

Q. Okay. And the Texas Medical Board is responsible for regulating physicians who perform surgeries in their offices using certain forms of anesthesia; is that correct?

A. If you mean office-based anesthesia, yes.

Q. Okay. And can you explain what actions by a physician trigger the regulations in this regard? When do those regulations apply?

A. Well, if a physician is administering an anesthetic in a level at which the patient is no longer independently ambulatory, there is a requirement for registration. And along with that requirement for registration, there are requirements related to what types of equipment or training must be obtained by the staff in a given location.

Q. And there are also reporting requirements?

A. There are reporting requirements, yes.

Q. And what is required to be reported?

A. If there is an unanticipated event at one of those facilities, they are supposed to make a report to the Medical Board.

Q. And in this context, does an unanticipated event mean a complication?

A. It could, yes.

Q. Okay. So when you say "a level of anesthesia that renders [89] the patient no longer ambulatory," would general anesthesia fit that category?

A. Yes.

Q. Would deep sedation fit that category?

A. Probably.

Q. And approximately how many physicians have registered with the Texas Medical Board for using either general anesthesia or deep sedation in their private physician offices?

A. Several thousand.

Q. So a lot of physicians perform surgeries using general anesthesia in their offices?

A. I don't know that they're using general anesthetic. They could be using different types of anesthetic. But we have several thousands that have registered for office-based anesthesia.

Q. But to the best of your understanding, minimal sedation wouldn't trigger registration; is that correct?

A. No. That is not my understanding.

Q. So it's your understanding that use of minimal sedation would trigger registration?

A. It depends on what you mean by "minimal."

Q. Well, you're the regulatory authority. What do you mean by "minimal"?

A. So there are instances where a patient may be given a relatively high dose of a relaxation drug that makes them not [90] able to safely walk around on their own, but that is nowhere near general anesthetic. So that's a very wide gulf between the two.

Q. Okay. But so under this regime, physicians are permitted to use those forms of anesthesia in their private offices so long as they register and comply with the training and reporting requirements that you've talked about; is that correct?

A. As well as the requirements related to the equipment, yes.

Q. Okay. And you said thousands of physicians in Texas engage in this practice; is that correct?

A. Yes.

Q. What is your understanding of why physicians using office-based anesthesia are regulated in this manner?

A. I believe that this arose out of Sunset recommendations, when all of the licensing agencies went through a Sunset evaluation. If I recall correctly, there was a very high-profile case of a young child who died, I believe it was in a dental office, when anesthetic was used but the proper training and equipment was not available. And so the legislature ultimately passed laws to ensure the safety of the administration of anesthetic in offices.

Q. Use of high-level anesthetics poses significant risks to the patient. Would you agree?

A. It can.

[91] Q. To the best of your knowledge, physicians engaging in use of outpatient—I'm sorry.

To the best of your knowledge, physicians engaging in use of anesthesia of the kind you described in outpatient settings aren't required to meet the minimum standards for ambulatory surgical centers in their private offices; is that correct?

A. I don't know. We don't oversee ambulatory surgical centers. I don't know what those requirements would be. All I know are the things we oversee.

Q. But the Texas Medical Board doesn't enforce any requirement like that; is that correct?

A. Right. We don't enforce any of those standards.

Q. But you do enforce the ambulatory surgical center requirement that applies to abortion providers, correct?

A. I'm sorry. I have no idea what you mean. We do not oversee ambulatory surgical center registrations or inspections.

Q. What is your understanding of why you've been named as a defendant in this lawsuit?

A. Well, primarily, I would assume it's because we are the authority that can act on a physician's license.

Q. And are you aware that Texas House Bill 2 gives the Texas Medical Board specific authority to discipline physicians for failing to comply with the requirement that licensed abortion [92] facilities meet the minimum standards for ambulatory surgical centers under Texas law?

A. I'm aware that we can take action against any physician for failure to follow any state law in connection with the practice of medicine. So if—if that is—that would also encompass House Bill 2.

Q. So you're not familiar with the specific requirement in House Bill 2?

A. I would—as far as I know, the ambulatory surgical requirement is not in place yet, so that is not something we're dealing with at this time. If you're representing to me that there are specific additional requirements, then I am happy to accept that representation.

Q. You testified at your deposition that you were called to testify at the legislature during the hearings on Texas House Bill 2; is that correct?

A. I testified that I was called to be present for House Bill 2 in the interim session but that I did not testify.

Q. And you had no understanding of why you were asked to be present as a representative of the Medical Board?

A. I never said that. I mean, they asked us to be there. I don't know—they don't share with us why they ask you to be there. The legislature has their own priorities and does what they need to do. They asked us to be there for a resource witness. I showed up as resource witness if they needed [93] information related to the regulation of physicians. I don't regulate ambulatory surgery centers. I didn't then either.

Q. Okay. So you're saying that, as the executive director of the Texas Medical Board, you don't have any understanding of the authority granted to the

Medical Board by Texas House Bill 2 specifically to discipline abortion providers. Is that fair?

A. No. What I'm trying to say to you is, the Medical Board has the authority to oversee physicians, period. We regulate their license in the State. As it relates to House Bill 2, an individual physician, we would have the ability to regulate them. As it relates to other laws that relate to physicians, we have the ability to regulate them.

Q. Okay. So you're saying that you see no reason why physicians who provide abortion services should be regulated any differently from other physicians in the State; is that right?

A. No. I'm saying that we regulate physicians as the law delineates by the legislature. It is not up to me to determine the purpose behind why a law should be passed. It is up to our agency to enforce that law, and that is what we will do.

Q. All right. Let me try one more. Are physicians who use anesthesia of the kind that triggers registration under the office-based anesthesia regulations required to have admitting privileges at a local hospital?

[94] A. Not per our board rules, but they are required to have an agreement in place in relation to what would happen if a patient needed to be admitted.

Q. And that was the same requirement that applied to abortion providers prior to the enactment of House Bill 2; is that correct?

A. I do not know if you're relating to the ambulatory surgical center. I don't know anything about those requirements.

Q. Got it. You don't know anything about the requirements.

Thank you very much.

MR. SOTO: Nothing from the State.

THE COURT: All right. You may step down. This probably, before we get into another witness, is as good a point to take a lunch break as any. So I'll let you have a little extra time today before we get into the next witness. So at this time we'll be in recess until 1:30.

(Recess)

(Open Court)

THE COURT: Ms. Kane, was she going to cross when we recessed or had we—I guess we finished with the witness. So does the State have another witness?

MR. STEPHENS: Yes, Your Honor.

THE COURT: All right.

MR. STEPHENS: The State calls Dr. Peter Uhlenberg.

[95] (Witness sworn)

PETER R. UHLENBERG,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. STEPHENS:

Q. Dr. Uhlenberg, could you state your full name for the record?

A. Peter Roslton Uhlenberg.

Q. And to your right is a binder containing a document titled Direct Testimony of Peter Uhlenberg. Do you see that document?

A. Yes.

Q. And could you take a moment to review that document.

A. Yes.

Q. Dr. Uhlenberg, does that reflect a full and accurate statement of the direct testimony you're prepared to offer today?

A. It does.

MR. STEPHENS: Your Honor, the State would offer the document titled Direct testimony of Peter Uhlenberg, Ph.D., as the live direct—as the direct testimony of Dr. Uhlenberg in this case.

MR. BROWN: Your Honor, we have two objections to paragraph 7 and paragraph 18. That testimony is hearsay. It describes the actions of certain abortion providers and purported abortion providers based solely on media reports and [96] Web sites.

THE COURT: Mr. Stephens?

MR. STEPHENS: Your Honor, paragraph 7 is a quite lengthy paragraph, so I'm—

MR. BROWN: The second half, perhaps.

MR. STEPHENS: On page 6?

MR. BROWN: Yes. It's a *New York Times* article, an article from *The Guardian*. Paragraph 18 is the Web site of a purported abortion provider and another media source.

MR. STEPHENS: Well, Your Honor, first, this is an expert opinion, and I don't think the witness is offering factual testimony regarding the statements for which he's relying on information that he read in a newspaper article. And that's with respect to paragraph 7 And paragraph—I'm sorry. What was the other one?

MR. BROWN: Paragraph 18. But I'll point out in paragraph 7, it is offered for the truth of the matter asserted. It says, "Abortion clinic in Wisconsin obtained admitting privileges." There's a cite to a newspaper article. "An abortion clinic in North Dakota obtained admitting privileges." There's a cite to a

newspaper article. Paragraph 18, similar kind of testimony. So it absolutely is offered for the truth of the matter asserted.

THE COURT: Well, almost all of the experts' reports are based on hearsay. Very seldom does—what experts do is [97] examine hearsay and then state conclusions on the basis of hearsay. That may or may not be a good practice, but that's what experts do. So I'm going to overrule the objection and will allow him to the testify. But rest assured that this court will carefully review the conclusions. And to the extent they appear to be based on nothing more than hearsay from newspaper articles, they probably won't be given very much weight.

MR. BROWN: Yes, Your Honor.

MR. STEPHENS: And, Your Honor, with that ruling, is the testimony for Dr. Uhlenberg, the direct testimony admitted subject to the hearsay objection?

THE COURT: Pardon me?

MR. STEPHENS: Has the direct testimony of Dr. Uhlenberg been admitted subject to the ruling?

THE COURT: The objection to the direct testimony of Dr. Uhlenberg is overruled. The proffer noted Direct Testimony of Peter Uhlenberg, Ph.D., is admitted.

MR. STEPHENS: The State passes the witness, Your Honor.

THE COURT: Mr. Brown, is it?

MR. BROWN: Yes. Brown.

CROSS-EXAMINATION

BY MR. BROWN:

Q. Good afternoon, Dr. Uhlenberg.

[98] A. Hello.

Q. Pleasure to see you again. Do you recall being deposed in this case on July 25th?

A. Yes.

Q. And do you recall answering some questions about Vincent Rue at your deposition?

A. Yes.

Q. Do you recall testifying under oath that you did not discuss your opinions with Mr. Rue?

A. I probably said that.

Q. Do you recall saying that?

A. Not exactly.

Q. Would it help if I showed you your deposition? Would that perhaps refresh your recollection?

A. Yes.

Q. Okay. Would you please look at page 57.

A. Yes.

Q. I apologize. I gave you all my copies of the deposition, so let me grab two back. Sorry about that.

Do you see there on line 17 you were asked the question:

"QUESTION: Did you discuss any of your opinions with Mr. Rue?"

A. Yes. I see that.

Q. And your answer was no; is that correct?

[99] A. The answer was no.

Q. And do you recall testifying that you never spoke with Mr. Rue about the substance of your report?

A. About what?

Q. The substance of your report.

A. No.

Q. You don't recall that?

A. No.

Q. Well, if you'd look there on line 14 of that page, would that refresh your recollection?

A. Yes.

Q. And does it say: "Did you ever speak with him about the substance of your report?" And your answer is, "I don't think so"?

A. Correct.

Q. That wasn't true, was it, Dr. Uhlenberg?

A. I'm sorry?

Q. That wasn't true. Neither of those statements are true; isn't that correct?

A. As far as I know, I have not discussed with Dr. Rue the substance of the case or the opinions.

Q. Do you recall an E-mail from Mr. Rue in early June in which he sent you some data from DSHS on abortion clinic closings and the number of abortions performed and offered you several proposals for incorporating conclusions based on that [100] data in your report?

A. I don't remember that specifically. He did from time to time send references to articles.

Q. But you don't recall receiving data from Mr. Rue and suggestions as to how to incorporate that data in your report?

A. I don't recall that.

Q. Would it refresh your recollection about this early June E-mail to see it?

A. Sure.

Q. I'm just going to mark for identification this E-mail as Exhibit 228.

This is an E-mail from Vincent Rue to you dated Friday, June 6th; is that correct?

A. Correct.

Q. Do you recall seeing this E-mail?

A. I'm trying to recall what the Excel files were related to. I don't recall right now.

Q. But it is to you? That's correct?

A. Correct.

Q. And did you receive it?

A. Yes.

Q. And did you review this E-mail?

A. Sure.

Q. And does it say, "Attached are some ideas in a Word doc and four Excel file with the TX DSHS data"; is that correct?

[101] A. Yes.

Q. And there's some attachments there and a bunch of Excel files and then a Word document at the end. Do you see that Word document? It's at the end of the attachments there. It says TX AB data issues.docx?

A. Yes. Yes. Okay.

Q. Do you recall reviewing that?

A. I'm sure I did.

Q. Okay. If you flip the—well, I guess I have the exhibit here. Do you recall seeing this Word document?

MR. STEPHENS: Your Honor?

A. As far as I know.

MR. STEPHENS: The State objects to the use of this document as privileged work product conveyed to Dr. Uhlenberg through Mr. Rue.

THE COURT: All right. The objection is overruled. And let me again state my basis for my rulings on the objections the State has made.

It is this court's ruling that the State cannot have a consultant collaborate with an expert witness on a report and then shield it from that communication and that consultation from the opponent on the basis of work product. Once anybody discusses an expert report with the expert or corresponds with the expert, it becomes fair game and is open for cross-examination, just as it would be if the expert was [102] consulting with a member of the expert's staff or another expert or if it were an engineering report, just as an example, another engineer.

The plaintiffs will have a full opportunity to cross-examination—to cross-examine on all of the aspects of the report and determine whether the report was indeed the expert's own work or whether it was somebody else's work. So that objection is overruled.

MR. STEPHENS: Your Honor, the State's position is that this document was inadvertently produced and not subject to Judge Austin's ruling because it was prepared by counsel for the State.

THE COURT: Well, I'm going to rule that that objection is waived because it's been up on the display for a reasonable period of time and there have been questions asked about it.

MR. STEPHENS: Thank you, Your Honor.

THE COURT: You may proceed, Mr. Brown.

MR. BROWN: Yes, Your Honor.

Q. (BY MR. BROWN) Dr. Uhlenberg, this Word document you said you reviewed, does it in fact contain three proposed ideas from Mr. Rue as to how to present discussions of some data in your report?

A. Yes. I see that.

Q. And you did in fact discuss these proposals with Mr. Rue; [103] isn't that correct?

A. I don't believe I discussed them. I think I rejected them.

Q. So you don't recall discussing them with Mr. Rue by E-mail a couple of days later?

A. That's possible.

Q. And do you recall discussing how your expert report should address the difficult problem with the data that Mr. Rue had sent you on the 6th?

A. No. I don't recall this.

Q. You don't recall asking Mr. Rue for his help in solving your problem?

A. I'm sorry?

Q. You don't recall asking Mr. Rue for his help in solving your problem?

A. I may have asked him for specific information about closing of abortion clinics. I don't remember other things asking for his input.

Q. Would it refresh your recollection to see an E-mail in which you asked for his help in solving your problem?

A. Sure.

Q. I would like to mark this E-mail that I'm going to put up on the projector here as Plaintiffs' Exhibit 229, and I'll hand you up a copy because it's three pages.

So on the bottom there you'll see the E-mail that we [104] just discussed from Plaintiffs' Exhibit 228; is that correct? The "attached are some ideas in a Word doc and four Excel files with the TX DSHS data." Do you see them there at the bottom?

A. The bottom of page 1?

Q. Page 2?

A. Yes.

Q. And then if you flip to page 1 at the bottom, there's a reply; isn't that correct?

A. Yes.

Q. And it's from you; is that right?

A. Correct.

Q. And it's dated June 8th?

A. Pardon?

Q. Is it dated June 8th?

A. Yes.

Q. And did you write this E-mail?

A. Yes.

Q. And if you flip to page 2 near the end of the E-mail that you just testified you wrote, you'll see there's a proposed paragraph that you wrote in which you addressed how to address a problem with the data that you were grappling with. Do you see that?

A. Yes.

Q. And then below do you see it says, "I need your critical suggestions related to this paragraph"?

[105] A. Yes.

Q. Did you write that?

A. Yes.

Q. And then if you flip to page 1 again, there's a reply from Mr. Rue. Do you see that? It's at the top. It's dated June 9th.

A. Yes.

Q. And it's to you; is that correct? This reply is addressed to you?

A. Addressed to me, yes.

Q. And does he offer suggestions for how to deal with this problem in this paragraph?

A. Yes.

Q. Do you consider the three E-mails that we were just looking at here in Exhibit 229 a discussion of any of your opinions?

A. Is which a discussion of my opinion?

Q. Those three E-mails that we just looked at, are these three E-mails a discussion of your opinions?

A. Well, I'm really not sure.

Q. It's your opinion, and you don't know whether it's a discussion of your opinion or not?

A. It's not what I would have considered a discussion of my opinions. I had my opinions and was asking for particular information from him that would be helpful in making sure I [106] wasn't in error about when clinics had closed.

Q. And you—do you consider this a discussion about the substance of your report?

A. I'm not sure if there is anything in here substantively important. I—

Q. So you don't consider this to be a discussion of any substance; is that correct?

THE COURT: Mr. Brown, let him finish his complete answer before you ask your next question.

MR. BROWN: Yes, Your Honor.

A. I would have to look at my report and see if this is a substantive statement in my report.

Q. So it's you opinion that, unless you're discussing something that went into your report, no discussion is a discussion of the substance of your report. If it's a discussion of something you chose not to be put in your report, that would not be a discussion of substance; is that correct?

A. I was trying to make the point that what I have in my report is material that I wrote and thought important. If there were other things that were suggested to me and I rejected them, I wouldn't—at least at the deposition, I was not thinking of that as a discussion of the substance of my report.

Q. Okay. But something you chose to put in your report would be a discussion of the substance of your report; is that [107] correct?

A. Pardon?

Q. If you were discussing something you did choose to put in your report, that would be a discussion of the substance of your report?

A. I suppose so.

Q. But it's your position you never had any discussions with Mr. Rue on things you put into you report; is that correct?

A. That's what I said, yes.

Q. So do you recall a discussion you had on the 27th of June via E-mail with Mr. Rue just before your rebuttal report was due regarding the relationship between poverty and the likelihood that women would have abortion and whether the share of abortions occurring at ASCs in Texas was increasing?

A. No.

Q. You don't recall that conversation?

A. No.

Q. Would it refresh your recollection to see the E-mails in which you were discussing those topics?

A. Yes.

Q. Again, I'll give you a copy since it's multiple pages.

THE COURT: Did you have that marked, Mr. Brown.

MR. BROWN: No. I apologize, Your Honor. I'll mark it as Exhibit 230.

Q. (BY MR. BROWN) And if you look on the E-mail that's dated [108] the—well, first let me ask you: Is this a group of three E-mails between you and Mr. Rue on page 1?

A. Yes.

Q. And then on page 2 there's one more E-mail; is that correct?

A. Yes.

Q. On the subject of these E-mails is "rebuttal report"; is that correct?

A. Could you repeat that?

Q. The subject of these E-mails is "rebuttal report"; is that correct?

A. Yes.

Q. Do you recall this conversation now that you've had a chance to look at it?

A. Pretty much, yes.

Q. And if you look at the—if you look at the E-mail that you wrote on the 27th at 1 p.m., do you see your statement, "I did not add comments on poor women obtaining abortions because I don't think we have info on whether poor women are less likely to abort if cost increases. Also I did not comment on

increasing share of abortions occurring in ASCs because the share dropped in 2012." Do you see that?

A. Yes.

Q. Did you write that?

A. Yes.

[109] Q. And if you look at the top E-mail there on the front page of Exhibit 230, do you see where Mr. Rue says, "I realize the percent provided in 2012 is down by 1.4 percent from 2011. But the trend minus whatever happened in 2009 is pretty clear across seven years. Also perhaps you could avoid using 2012 data, as it has not been uploaded yet to the DSHS Web site. What do you think?" Did I read that correctly?

A. Yes.

Q. Do you know whether your final deposition testimony in this case includes a discussion of whether the share of abortions occurring in ASCs in Texas increased in the years leading up to 2012?

A. Yes, it does.

Q. And do you know if that discussion doesn't include the figure from 2013?

A. Right.

Q. Do you also recall testifying at deposition that the Attorney General's Office provided you with vital statistics data about abortions from 2012, a list

of abortion clinic openings and closings and four of plaintiffs' expert reports?

A. Could you repeat that?

Q. Sure. Do you recall testifying at deposition that the Attorney General's Office provided you with vital statistics data about abortions from 2012, a list of abortion clinic opening and closings, and four of plaintiffs' expert reports?

[110] A. Yes.

Q. And you testified that you didn't recall being provided anything else; is that correct?

A. I'm really sorry. I'm having trouble hearing.

Q. You testified that you didn't recall being provided anything else at your deposition; is that correct, by the Texas Attorney General's Office?

A. That's what I remembered, yes.

Q. Do you recall being provided with several articles by Mr. Rue on the afternoon of the 26th of June, four days before your expert report was due?

A. Not specifically.

Q. If you saw an E-mail from Mr. Rue to you dated June 26th attaching articles for you to review, would that refresh your recollection as to whether that happened?

A. Yes.

Q. I'm going to mark this exhibit as Plaintiffs' 231 for identification.

Is that an E-mail from Vincent Rue to you dated Thursday, June 26th?

A. Yes.

Q. Did you receive this E-mail?

A. Yes.

Q. And does it say, "Thank you very much for your expedited review of Plaintiffs' reports and assembling this excellent [111] rebuttal report so quickly. I greatly appreciate it. I made some small edits and suggested a few paras you might consider adding or rewriting. The articles I refer to are attached as well as the rebuttal report with my track changes."

Did I read that correctly?

A. Yes.

Q. And does the attachment line show that there are several articles attached there?

A. Yes.

Q. And do you recognize one that's referenced Jones and German 2014 abortion incidents?

A. Yes.

Q. Do you see that there?

A. Yes.

Q. Do you recall using that as a citation in your report?

A. I think so. I already had that, by the way.

Q. You have your testimony in front of you, your direct testimony? The tab 4, I believe, in the black binder that Mr. Stephens gave you. Is that there? I'm just asking if you have it in front of you.

A. The direct testimony, yes.

Q. Okay. Let me come and get those exhibits from you and get them out of your way.

MR. BROWN: Your Honor, at this time Plaintiffs would like to move Exhibits 228, 229, 230, and 231 into evidence.

[112] MR. STEPHENS: Your Honor, same objection as to the privileged nature of those communications.

THE COURT: And the same ruling. Plaintiffs'—the objections are overruled. Plaintiffs' Exhibits 228, 229, 230, and 231 are admitted.

Q. (BY MR. BROWN) So let's look at your testimony for a moment. If you wouldn't mind flipping to paragraph 7. And flip to the second page of paragraph 7, which is page 6, please.

And you state there, "Do you see that in a previous case heard in this Court, as a matter of fact, an opinion was offered that two of the five abortion clinics in Dallas County would close if the admitting

privileges requirement was to go into effect?" Do you see that?

A. Yes.

Q. And then you say, "Dr. Grossman's testimony in this case states that as of June 11th of this year, four of the five were open."

A. yes.

Q. Do you recall testifying in your deposition that Dr. Grossman's report also says that only three of the five were open on November 1st, 2013?

A. On what date?

Q. November 1st, 2013.

A. Yes.

[113] Q. The date of the admitting—

A. Yes.

Q. And that's the date that the admitting privileges requirement took effect, right?

A. Right.

Q. You also refer in the same paragraph of your testimony that the only clinic in North Dakota that was able to meet an admitting privilege requirement—excuse me—you state that the only clinic in North Dakota was able to meet an admitting privileges requirement; is that correct?

A. Yes.

Q. And your only source of information that you cite in that article is—excuse me—in that paragraph is an article published in the *New York Times* in February of 2014; is that correct?

A. That's the article I cite, yes.

Q. You don't have any other sources of information about that, correct?

A. No. I think I had additional sources. I typically put in one.

Q. What are your other sources of knowledge about that particular—

A. I would have to review that.

Q. So as you sit here today, you can't recall any sources other than the *New York Times* article?

[114] A. Not specifically.

Q. And do you recall testifying at your deposition that you didn't know whether the clinic was able do comply with the law before it took effect?

A. I would have to see what I said on that.

Q. We can look at that. If you flip to page 65 of your deposition, we're discussing the North Dakota clinic on this page; is that correct?

A. Are we on page 55?

Q. I'm sorry. 65.

A. Yes.

Q. And on line 13 you're asked: "Do you know whether the physicians discussed in that article obtained admitting privileges before the law took effect?"

A. Yes.

Q. Did I read that correctly?

A. Yes.

Q. And your answer is: "I know they obtained admitting privileges before the trial was scheduled to occur." Is that right?

A. Yes.

Q. And then you are asked whether the physicians obtained admitting privileges before the effective date of the law; is that correct?

A. Right.

[115] Q. And you say: "I don't know the effective date of the law."

A. Right.

Q. And then below that you're asked: "Do you have any knowledge regarding the North Dakota other than the media?" Is that correct?

A. Correct.

Q. And you answer is "no"; is that right?

A. Yes.

Q. Okay. Going back to paragraph 7 of your direct testimony, at the bottom of page 6 and it goes over into the top of page 7, you discuss a clinic in Wisconsin that had brought a lawsuit against an admitting privileges requirement that it was later able to comply with; is that—is that right?

A. Correct.

Q. But you also know that there was a second plaintiff clinic in that case which was unable to comply with the law; isn't that correct?

A. I don't know if that clinic was able or not before the law went into effect.

Q. But do you recall testifying at your deposition that you did know it was unable to comply with the law before it took effect?

A. Could you repeat it?

Q. Do you recall testifying something different at your [116] deposition?

A. No.

Q. So you don't recall saying at your deposition that you knew that the clinic was unable to comply with the law before it took effect?

A. I knew that it was unable to comply with the law before the trial was held. The law had not gone into effect as far as I know.

Q. Well, you know that the plaintiffs clinic was unable to obtain privileges; isn't that correct?

A. At the time of the trial?

Q. That's correct, yes.

A. Yes.

Q. But you didn't state that in your deposition—excuse me—in your direct testimony, did you?

A. No.

Q. And you also rely in this paragraph on an article in *The Guardian*; isn't that right?

A. Are we on the direct testimony now?

Q. Yes.

A. What paragraph?

Q. This is still paragraph 7 at the top of page 7.

A. Okay.

Q. So you cite a *Guardian* article—

A. Yes.

[117] Q. —regarding this—this lawsuit in Wisconsin is that right?

A. Yes.

Q. And you know that *The Guardian* article says that there are two plaintiffs in that case, and

one was able to obtain admitting privileges and one was not?

A. Yes.

Q. But you do not say that in your testimony?

A. No.

Q. And you testified at trial as an expert in that case, correct?

A. Correct.

Q. You stated in your deposition that you don't personally know whether Whole Woman's Health clinic in McAllen has plans to reopen; isn't that right?

A. Yes.

Q. And you've stated that you don't personally know whether Reproductive Services in El Paso has plans to reopen; is that right?

A. Yes.

Q. And you also stated you don't personally know whether the Whole Woman's Health clinic in McAllen is able to comply with the admitting privileges requirement; isn't that right?

A. Yes.

Q. And you stated you don't personally know whether [118] Reproductive services in El Paso is able to comply with the admitting privileges requirement; isn't that right?

A. Yes.

Q. That's right?

A. Yes.

Q. In paragraph 8 of your testimony, which is the next paragraph in the middle of page 7, you say: "The T-E-X-P-E-P, or TexPep, data estimates cannot be verified." Do you see that?

A. Yes.

Q. And by TexPep data estimates, are you referring to the data that Dr. Grossman relies on to develop his opinions offered in this case?

A. Yes.

Q. Do you recall testifying at your deposition that checking data against figures provided by government agencies is not the only way to verify data?

A. I may have said that.

Q. Does that seem right to you?

A. If you'll point me to what I said.

Q. Sure. Take a look at page 74 of your deposition transcript. And if you look from line 18 down, you're asked: "Is the only way to verify data to check it against other data provided by a government agency?" And your answer after an objection is "I don't know." Isn't that right?

[119] A. Yes.

Q. And below that you're asked again: "Are you familiar with any ways to verify data other than to check it against other data provided by a government agency?" And then on the next page you say "yes." Isn't that correct?

A. Yes.

Q. And you give a list of ways; isn't that right?

A. Yes.

Q. And the list of ways include comparing it with past records, looking at how questions were asked, looking at the response rate, looking at the basis for reporting of data. That's correct?

A. Right.

Q. And then you also testified that, in your own academic research, you've used data that has been verified in those ways; isn't that right?

A. Yes.

Q. And do you recall testifying that some of those methods could be used to add confidence that Dr. Grossman's data are correct?

A. Some of those might be used.

Q. But do you recall saying at your deposition that they could be used to add confidence that Dr. Grossman's data are correct?

A. Again, if you'd point me to what you're referring to.

[120] Q. Sure. It's on page 78 in the middle of the page. Maybe look at lines 15 and 16?

A. Yes.

Q. Does that refresh your recollection that you testified some of those methods could be used to add confidence that the data are correct?

A. Yes.

Q. Let me point you to the next paragraph of your direct testimony. If you'll flip to page 8, there's a bullet point. It's the second bullet point of paragraph 9. And you state that an average of approximately—excuse me. Let me withdraw the question.

You state: "For clinics that have closed, unidentified knowledgeable sources were asked to estimate the monthly number of abortions and the number of patients from the lower Rio Grande Valley." Do you see that?

A. Yes.

Q. Do you recall testifying at deposition that there would have been a better way to phrase that sentence?

A. Yes.

Q. What would be the better way to phrase that sentence?

A. For clinics that did not—someone from the clinic that had closed did not provide information,

then unidentified knowledgeable sources were asked to estimate.

Q. So just so I understand, if the sentence read "for clinics [121] that had closed and were unable to provide information" is the better way to read that first clause?

A. It would be better.

Q. Okay. But that wasn't—that's not—not what your direct testimony says, correct?

A. No. I didn't correct that.

Q. Okay. If you go to the final bullet point of that paragraph, which is page 9 now, you say: "An average of approximately 11.1 percent of all TxPEP data was based on knowledgeable sources or internal estimates, correct?

A. Yes.

Q. Do you recall discussing this opinion at your deposition?

A. Yes.

Q. And did we use the number 11.1 during that discussion?

A. Excuse me?

Q. Did we discuss the number 11.1 in the deposition?

A. I don't recall. I told you that the—the number I had listed was not correct.

Q. Okay. Do you believe this number, 11.1, is correct?

A. I believe it is.

Q. So does that mean that 88.9 percent of the data that Dr. Grossman relies on is reported by clinics or by physicians or staff who had worked there before the clinics had closed?

A. Yes.

Q. If you could flip the page once more to paragraph 11. And [122] in this paragraph you're discussing data relied upon by Dr. Joseph Potter in an earlier case; is that right?

A. Yes.

Q. And you compare the data to the data that's used in this case; is that right?

A. I say that in both cases, the data are coming from TxPEP, yes.

Q. But you acknowledge that the data are not the same data, correct?

A. Correct.

Q. And Dr. Grossman does not use Dr. Potter's data in his opinions; is that correct?

A. I think that's correct.

Q. And you also testified at your deposition that Dr. Potter's analysis was prospective, right? He was offering a prediction as to the number of abortions that would decrease in the future; isn't that right?

A. Yes.

Q. And you also testified at your deposition that Dr. Grossman was performing a retrospective analysis. He was estimating the number of abortions that had occurred over a period of time in the past; isn't that right?

A. That's part of his analysis.

Q. You also state in that paragraph 11 of your direct testimony on the next page that Dr. Grossman estimates a [123] decline in the annual number of abortions in Texas as 3,622, comparing the year before and after the effective date of the admitting privileges requirement; is that right?

A. Yes.

Q. And you acknowledged in your deposition that 3,622 is not a number that Dr. Grossman himself uses, right?

A. Right. It comes from his data.

Q. Right. So do you recall that Dr. Grossman's report referring to three periods of time that he calls one, two, and three?

A. Yes.

Q. And these are six-month intervals ending April 1st, 2013; is that right? Excuse me. April 30th, 2014.

A. Yes.

Q. I misspoke. So 3,622 is a comparison of the decline in the number of abortions between what Dr. Grossman would call period two and period three; is that right? An annualized comparison, I should say?

A. It's doubled from the first six-month period—of the six months in period three.

Q. I'm sorry. I didn't understand your answer.

A. The—the difference between period two and period three times two because we're dealing with six months. So on an annual basis, this is an estimate.

Q. Okay. So you take the difference between period two and [124] period three and you multiply it by two because that would make, essentially, a year?

A. Yes.

Q. Okay. And Dr. Grossman didn't compare periods two and three in his report; isn't that right?

A. Correct.

Q. He compared period one and period three; is that right?

A. Correct.

Q. And period one and period three cover the same time of year, right, a six-month period beginning November 1; isn't that correct?

A. Yes.

Q. And period two and period three covered different times of year; isn't that correct?

A. Yes.

Q. Six months before and after a November 1st end date?

A. Yes.

Q. You testified at your deposition that you didn't know whether the abortion rate in Texas varies seasonally; isn't that correct?

A. That's correct.

Q. And you didn't research that to form the opinions that are expressed in your testimony; isn't that right?

A. Right.

Q. But you did testify at your deposition that you understood [125] that the admitting privileges requirement was passed during period two; isn't that correct?

A. Yes. It was enact—it was passed.

Q. Excuse me. That it was—yes. It was passed.

And you also testified your understanding that Dr. Grossman found that the number of abortions clinics fell by almost 20 percent over the course of period two; isn't that correct?

A. I couldn't testify to the number, but a certain number closed, yes, in period two.

Q. Would it refresh your recollection to look at the page of your deposition testimony in which you testified to this?

A. Yes.

Q. Why don't you look to page 99. Do you see at the bottom when you were asked: "How many abortion clinics does Dr. Grossman calculate were operating on May 1st, 2013?"

A. Yes.

Q. And you said 41?

A. Yes.

Q. And May 1st, 2013 is the beginning of period two; isn't that right?

This isn't in your transcript. I'm sorry. I'm just asking you.

A. I think so.

Q. And then on the next page of your transcript you're asked: [126] "How many abortion clinics does Dr. Grossman state were operating on October 31st, 2013?" And your answer is 33; is that right?

A. Yes.

Q. And October 31st, 2013 is the last day of his period two; isn't that right?

A. Yes.

Q. So it's fair to say that, over the course of period two, the number of abortion clinics that Dr. Grossman calculated were open fell from 41 to 33; is that correct?

A. That's what he reports, yes.

Q. And then the admitting privileges took—excuse me. The admitting privileges requirement took effect on the first day of period three; isn't that right?

A. Yes.

Q. Do you also recall testifying that the decrease in abortions comparing period one and three, the same comparison that Dr. Grossman made, was 13 percent?

A. Yes.

Q. And you said that was a greater decrease than that which occurred between 2010 and 2011 in Texas; isn't that right?

A. Yes.

Q. And you also said it was a greater decrease than occurred from 2011 to 2012; isn't that right?

A. Yes.

[127] Q. And you also testified at your deposition that one of the sources you rely on to form your opinion reported an annual decrease in the United States in the abortion rate of 13 percent over the three-year period from 2008 to 2011; isn't that right?

A. As I recall, that comes from Dr. Grossman's report.

Q. Well, would it refresh your recollection to look at the portion of your deposition testimony in which you testified that you were actually looking at a source that you rely on to form your own opinions?

A. Yes.

Q. If you look at page 113 of your testimony, you'll see it there. Start at 112. I'm sorry. No. Let's go to 113. I apologize. I'm a little backwards today.

We're looking at the *Abortion Incidents and Service Availability* article on page 113; isn't that correct?

A. Are we referring to the *Abortion Incidents* article?

Q. Uh-huh.

A. Yes.

Q. And on page 113 you're asked the question: "On the following page of the article, it says the number of abortions and the abortion rate both decreased 13 percent between 2008 and 2011. Did I

read that correctly?" And your answer is "yes." Is that right, Dr. Uhlenberg?

A. Yes.

[128] Q. So over that three-year interval, then, that's the same reported decrease that Dr. Grossman reported finding between period one and period three, right? Thirteen percent?

A. Yes.

Q. And that article, *Abortion Incidents*, that is the article that you refer to in paragraph 13 of your direct testimony; isn't that right?

A. Yes.

Q. During the deposition you also testified that you didn't know whether any laws took effect during the period that the article analyzed requiring abortions to be performed at ASCs, correct?

A. I'm sorry. In what state?

Q. Any state.

A. And the question again?

Q. The question is: Do you recall testifying at your deposition whether the article encompassed any laws that took effect in any date during the period it was analyzing that required abortions to be performed in ASCs?

A. Yes. You asked that question.

Q. And do you recall saying you didn't know?

A. I think you had me refer to the article to see if it was listed there.

Q. Uh-huh.

A. And it wasn't specifically listed.

[129] Q. So your opinion was that you didn't know whether any laws took effect in the United States between 2008 and 2011 that required abortions to be performed in ASCs and so were included in the analysis in the article; is that correct?

A. Yes.

Q. And you also don't know whether that article considers any law in its analysis that resulted in the closure of any abortion clinic; isn't that right?

A. Yes.

Q. And you also testified that the authors of the article rely on data about abortion patients that are provided to them by abortion providers; isn't that right?

A. Yes.

Q. And you also testified that you knew that the authors of that study relied on estimates on the number of abortions performed provided to them from knowledgeable sources when they were unable to obtain patient numbers from abortion providers themselves; isn't that right?

A. Yes.

Q. And do you recall whether the authors of that study make their own estimates for patients at facilities that they had neither provided reported numbers—excuse me—neither provider reported numbers nor estimates from knowledgeable sources?

A. I think they do.

[130] Q. And this is an article that you rely on in your direct testimony; isn't that right?

A. Yes.

Q. Can we flip ahead to page 18—excuse me—paragraph 18. This is page 16 of your direct testimony.

Do you recall discussing a paragraph essentially the same as this at your deposition?

A. Not specifically.

Q. Do you recall discussing a figure of 3,642, and you were saying it was described erroneously in your expert report?

A. I don't recall that.

Q. Well, here in your deposition testimony—excuse me—in your direct testimony, you offer the figure of 3,642 abortions performed in Texas at or after 16 weeks gestation in the year 2003; is that correct?

A. Yes.

Q. And you cite this article by Colman and Joyce.

A. Yes.

Q. Is that sentence correct? Were there 3,642 abortions performed in Texas at or after 16 weeks in 2003 according to Colman and Joyce.

A. I believe we discussed that that is the number of abortions performed on residents of Texas in that—at 16 weeks-plus gestation in that year.

Q. Okay. And, in fact, we discussed that that number refers [131] to abortions performed for residents of Texas within the State of Texas?

A. That's correct.

Q. But that change is not reflected in your direct testimony; isn't that right?

A. Correct.

Q. So if your direct testimony were corrected, it would read "In 2003 there were 3,642 abortions performed in Texas for Texas residents at or after 16 weeks gestation," correct?

A. Yes.

Q. Now, do you recall testifying at your deposition that the Colman and Joyce article that you relied on for this statement reported somewhere over 3,000, but less than 4,000, abortions performed in Texas for Texas residents each year from 2001 to 2003?

A. Yes.

Q. And do you recall discussing that, after the ASC requirement took effect in 2004, that the number of abortions performed in Texas for Texas residents at or after 16 weeks fell below 2,000 and never regained its former level?

A. Yes.

Q. And do you recall that that is what the Colman and Joyce article that you cite here reports, correct?

A. Yes.

Q. If you flip the page of your direct testimony, you'll see [132] that there's a discussion of the Texas Women's Reproductive Health Initiative. Do you see that?

A. Are we on page 17?

Q. Yes.

A. Yes.

Q. And you testified at your deposition that your understanding of the Texas Women's Reproductive Health Initiative comes solely from their own Web site and couple of media articles; is that correct?

A. Yes.

Q. And you testified that—that you knew as of the date of the deposition that Texas Women's Health and Rights Initiative had posted notice on its Web

site that their project is on hold because they had only collected $50 in donations; isn't that right?

A. Yes.

Q. But you didn't state that in your expert testimony, did you, here today, the one that we're looking at?

A. No.

Q. It doesn't say that TWRHI's initiative is on hold because they have only collected $50 in donations, correct?

A. Correct.

Q. And you also testified at your deposition that you have no opinion about whether the Texas Women's Health and Rights Initiative is likely to build any ASCs in Texas at all; isn't [133] that correct?

A. Correct.

Q. You also testified at your deposition that the research tends to show that abortion rates for women living further from an abortion provider are lower than those living near an abortion provider; isn't that right?

A. Yes.

Q. You've offered an expert opinion in about nine or ten cases involving restrictions on abortions; isn't that right?

A. Yes.

Q. And in every case you've testified in favor of a law that would impose restrictions on abortion; isn't that right?

A. Yes.

Q. You testified at your deposition that you had never done any research regarding abortion except in connection with litigation and teaching one unit of your population class; isn't that correct?

A. I don't recall that.

Q. Would it refresh your recollection to look at your deposition transcript?

A. Yes, please.

Q. Please take a look at page 37 of your deposition transcript. Excuse me. Thirty-two. And on line 7 you're asked the question: "All of your research regarding abortion has been involved with your participation in lawsuits; is that [134] correct?" And then you give the answer, "I may—I think I also did some research in preparation for teaching a unit on abortion in my population class." And then you're asked the question: "And none of this research has led to any publications; is that correct?"

A. Yes.

Q. And you said "correct."

Did I read that correctly, Dr. Uhlenberg?

A. Yes.

Q. Are you a professor of sociology at the University of North Carolina?

A. As of July 1st I'm professor emeritus.

Q. And you're also a fellow emeritus at the Carolina Population Center; is that right?

A. At the Carolina Population Center, yes.

Q. Do you have a binder of Defendants' exhibits in front of you? It should say Defendants' Exhibits. Maybe—I'm just asking if you have it. If you don't, I'll bring it up to you. It doesn't appear that you do.

A. I'm not sure what you're asking.

Q. If you a have a binder labeled "Defendants' Exhibits" in front of you.

A. Yes.

Q. Does it say "Defendants' Exhibits" in front of it—on the top?

[135] A. It says "Plaintiffs' Trial Exhibits."

Q. Okay. Let me bring you one that says "Defendants' Exhibits."

Could you flip to tab D-55 in there.

A. Yes.

Q. Is that your CV?

A. Yes.

Q. Does it need to be updated in any way?

A. Excuse me?

Q. Does it need to be updated in any way?

A. Yes. I should list "professor emeritus" at this point.

Q. So the CV doesn't say that you're an emeritus either at UNC or the Carolina Population Institute?

A. Correct.

Q. But that would be correct if it said that?

A. Yeah. I have not corrected it up to this point.

Q. Okay. You can put that aside. You've published a number of—of items other than things about abortion; isn't that right?

A. Yes.

Q. And one of the things you've published is a book chapter entitled "Population Problems and Christian Responsibility"; isn't that right?

A. Yes.

Q. Do you recall writing in that book chapter, "Few [136] sociologists concerned with population problems approach their research and writing from the perspective which includes the existence of a supernatural god who created and sustains the universe"?

A. I wouldn't have recalled it, except I think you had me read that at deposition.

Q. And as you sit here, do you recall that now?

A. Yes.

Q. And do you recall testifying at deposition that you are one of those sociologists?

A. Excuse me?

Q. Do you recall testifying at your deposition that you are one of those sociologists?

A. Yes.

Q. And do you also recall writing, "The exciting challenge confronting the Christian student is to take the material that is offered and to test it against what is revealed in the Bible. Through this process, some findings must be rejected as contrary to a Christian understanding of reality"?

A. Yes.

Q. Do you recall writing that?

A. Yes.

Q. And do you recall testifying at your deposition that you said that, in your work, you implicitly test the material that is offered you against what is revealed in the Bible?

[137] A. I try to do that.

Q. And do you also recall writing in that article—excuse me—in that book chapter, "As Christians, we do not have the option of stopping with a disinterested analysis of social problems. We must go on to ask the question, What should our response be?"

A. Yes.

Q. And do you recall testifying in deposition that you said your work goes beyond a disinterested analysis of social problems?

A. Excuse me?

Q. Do you recall testifying at deposition that your work as a sociologists goes beyond a disinterested analysis of social problems?

A. Yes.

Q. And do you recall testifying at your deposition that children are a gift from God, and you shouldn't interfere in the birth of a child?

A. Yes.

MR. BROWN: Pass the witness, Your Honor.

REDIRECT EXAMINATION

BY MR. STEPHENS:

Q. Dr. Uhlenberg, you were asked a number of questions by Mr. Brown about your knowledge of abortion clinic openings and closings. Do you recall those questions?

[138] A. Yes.

Q. And what is the source of your knowledge of certain possible clinic openings in the State of Texas?

A. Based on news items I've read.

Q. Okay. And is the document that—do you recognize the document that I just handed you?

A. No. I'm not familiar with that.

Q. Could you read the title of that document.

A. On the first page, "Building Our Future Fund."

Q. Yes. And I believe on the second page where it begins with "statement."

A. Yes. Okay.

Q. And on the first page, is that document marked as Defendants' Exhibit D-4 on the first page?

A. Yes.

Q. And in your testimony you refer to the possibility of additional ASCs opening in the State of Texas; is that right?

A. Yes.

Q. And I believe you cited a newspaper article. Do you recall that?

A. Yes.

Q. And—

A. Or a Web site.

Q. Right. And that Web site linked to a press release; is that right?

[139] A. I don't recall.

Q. Okay. Is that—is that press release pertaining to the possible opening of an ASC in the State of Texas?

A. Yes.

MR. STEPHENS: Your Honor, the Defendants' would move for the admission of Defendants' Exhibit 4 into evidence.

MR. BROWN: Objection, Your Honor, because it's hearsay. The defendant hasn't authenticated it. He said he doesn't recall seeing it before. It's a press release he didn't write. I assume it's a press release. I—it's up at the witness table.

THE COURT: Sustained.

Q. (BY MR. STEPHENS) Dr. Uhlenberg, did your communications with Dr. Rue influence your opinions in this case?

A. No.

Q. And did your communications with Dr. Rue change the ultimate opinions you're offering in this case?

A. No.

Q. Are the statements and opinions in your direct testimony your opinions and yours alone?

A. Yes.

Q. Do you stand by those statements and opinions today?

A. Yes.

Q. I've handed you Dr. Grossman's direct testimony submitted in writing in this case, and I'd like for you to read aloud [140] paragraphs 8 and 9 of his—of Dr. Grossman's testimony. It begins at the bottom of page 2 and continues on to page 3.

A. Yes. He writes: "I am co-investigator of the Texas Policy and Evaluation Project, which is a research project undertaken jointly by the University of Texas at Austin, Ibis Reproductive Health, and the University of Alabama at Birmingham. Since 2011 the Texas Policy Evaluation Project has been tracking the number of open facilities providing abortion care in the State by intermittently requesting information from the Texas Department of State Health Services, parenthesis, DSHS, on licensed abortion providers. Through interviews with clinic staff and review of publicly available information, we identified clinics that ceased providing abortion services during the three time periods: One, November 1, 2012 through April 30, 2013; two, May 1st, 2013 through October 31, 2013; and, three, November 1, 2013 through April 30, 2014. We did not include hospitals or physicians not licensed as abortion facilities in our analysis

because they perform only a very small percentage of abortions in Texas. In 2012 the percentage was 0.3 percent. We also calculated changes in distance that reproductive-age women in Texas must travel to access a licensed Texas abortion provider as well as changes in the abortion rate during this time frame.

"9. Our findings were recently accepted for publication in the peer-review journal *Contraception*."

[141] Q. Thank you. Now, does paragraph 8, which you just read, accurately reflect your understanding of part of the expert report and testimony provided by Dr. Grossman in this case of the study that he conducted?

A. Yes.

Q. And your testimony, in part, is in rebuttal to that analysis and opinion provided by Dr. Grossman?

A. Yes.

Q. And as you read in paragraph 9, Dr. Grossman testified on direct that the findings of that study and analysis were accepted for publication by the peer-reviewed journal *Contraception*; is that right?

A. Yes.

Q. Dr. Uhlenberg, do you recall if you've seen this document before?

A. Yes. I read that.

Q. Okay. And this document is the complaint filed in the pending lawsuit; is that right?

A. Yes.

Q. And this is the last page of the complaint. If you look at the top, it says page 32 of 32. Do you see that?

A. Yes.

Q. And there's a signature block. Do you see the signature block?

A. Yes.

[142] Q. And what's the name—the first name at the top of the signature block?

A. You're asking about the signature?

Q. Well, no. I'm asking the name below—the first name below the signature line?

A. Stephanie Toti.

Q. Dr. Uhlenberg, Dr. Grossman testified in this court two days ago that this document, the accepted manuscript, is the document published in *Contraception* referred to in program 9 of his direct testimony. Could you read the fourth name of the author listed in this article.

A. Well, that's Stephanie Toti.

MR. STEPHENS: No further questions, Your Honor.

THE COURT: Mr. Brown?

MR. BROWN: Nothing further, Your Honor.

THE COURT: All right. You may step down.

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS (AUSTIN)

(Admitted Aug. 7, 2014)

EXHIBIT
P-223
1:14-CV-284-LY

From:	Vincent M. Rue <vincerue@bellsouth.net>
Sent:	Friday, June 20, 2014 4:31 PM
To:	'Debra Kitz'
Subject:	RE: question
Attachments:	Layne-Farrar Expert Report—Part I.pdf

Debbie—

Please understand I was just rushing to provide you with the basis for your rebuttal report, not a final draft by any means, and not submitted to anyone but you. I wanted you to look over Layne-Farrar for background mostly and neglected to send it in my rush to get stuff out to experts. I apologize. It is in two parts and I am attaching the final part here.

As to your signature, again, I simply changed the title of your expert report that you had already signed off on, and the date at the end, and the documents you reviewed to reflect these two new expert reports so as to provide you with a working document. Please be assured I would never submit any work product without your explicit authorization. Removing your signature from this draft is a simple right click if you

are more comfortable with it not being placed onboard until the draft is finalized. It was simply part of your expert report and came along with my quick edits.

Thanks for your understanding.

Vince

From: Deborah Kitz [mailto:dkitz@broshar consulting.com]
Sent: Friday, June 20, 2014 4:54 PM
To: Vincent Rue
Subject: question

Vince – I see that "my" report that you returned to me yesterday references my review of an expert report from a Dr. Layne-Farrar. I have not ever seen such a report. To what does that refer?

For the future, to protect all concerned, please do not attach my signature to any report until I send an email providing an "OK to sign" Thanks.

Deborah S. Kitz, Ph.D.
Principal, Broshar Consulting
Expert Solutions For Your Health Care Challenges
(215) 793-0703
www.brosharconsulting.com

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS (AUSTIN)

(Admitted Aug. 7, 2014)

EXHIBIT
P-229
1:14-CV-284-LY

From: Vincent M. Rue <vincerue@bellsouth.net>
Sent: Monday, June 09, 2014 2:52 AM
To: 'Peter Uhlenberg
Subject: RE: TX DSHS Data
Attachments: Abortion Facilities—Initial licenses May 2002-Sept 2013.xlsx; UHLENBERG TX II EXPERT

Peter—

Thanks very much for taking the time to review this data. Attached is a spreadsheet which identifies by year when abortion clinics opened between 2002-13 according to DSHS (all data from them). Of course, an individual abortion clinics must be checked against the closure data provided previously to see if it remains licensed and active.

I don't know what to tell you re the Harlington clinic closing date. DSHS data is the official source, but what clinics do is often not what clinics say. Perhaps the clinic was operating illegally after 2008 or under the monthly number required to have licensure—I just don't know at this point. I'll check and see what DSHS thinks. A news item reported below suggests Dr. Minto just closed his clinic this year:

http://www.mprnews.org/story/2014/28/court-hands-setback-to-texas-abortion-rights-law-supporters

I have added the para you wrote—para#10 in the attached draft report deleting the final sentence as I don't think it helps our argument sufficiently. The cite requested was inserted.

May I ask you to look over your WI report and see if there is anything from that or something else you might want to add to your TX report?

Thanks Peter.

Vince

From: Peter Uhlenberg
[mailto: uhlen@email.unc.edu]
Sent: Sunday, June 08, 2014 4:22 PM
To: Vincent M. Rue
Subject: Re: TX DSHS Data

Vince—

I have spent a lot of time looking at the data you sent to find something useful, but without success. Your point 3 (Harlingen closing) would be good, but news reports say it was open and operating until November 2013 ["Dr. Lester Minto, who owned and operated Reproductive Services of Harlingen, the only other abortion clinic in the Rio Grande Valley, told the San Antonio Express-News he closed his doors after 30 years last week. Minto stopped performing abortions in November after new rules requiring hospital admitting privileges went into effect and he was

unable to secure them. Miller's clinic in McAllen also stopped performing abortions in late October.] Other reports confirm this—so I don't know what to make of the 2/7/08 closure date, unless it re-opened after that.

I have looked at number of abortions in several counties where abortion clinics closed—the results are NOT helpful. Great care is needed in interpreting the reported closings (Harlingen case; abortion clinics that changed to ASCs no longer need abortion clinic license). I did not receive data on new abortion clinic licenses issued since 2002—but number of licensed clinics has been declining.

I did find the info on recent closings interesting—many more than I had expected.

I can add something like this in my report:

"Many abortion clinics in Texas have closed in the past without a drop in number of abortions. In 2002 the number of Texas residents having abortions was 76,278. Between 2003 and 2006, the state reports that 24 abortion clinics closed [I need a reference for the data you sent]. Nevertheless, the number of abortions was greater in 2007 (77,811) than it was in 2002. A reasonable explanation is that when abortion clinics close (for whatever reason), existing abortion clinics expand or new ones open to meet the demand." ?add "Between 2008 and 2011 the number of abortions declined sharply (from 78,330 to 70,013), but only 4 clinics closed in 2009-2011. As the demand for abortions declines, one might expect an increase in

abortion clinic closings, regardless of new regulations of abortion clinics."

I need your critical suggestions related to this paragraph.

Peter

On 6/6/2014 11:36 PM, Vincent M. Rue wrote:

> Peter—
>
> Attached are some ideas in a Word doc and four Excel files with the TX DSHS data. Please let me know what you think or if you need anything else. Our deadline for expert reports to be submitted is June 16.
>
> Many thanks.
>
> Vince

[LOGO]
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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS (AUSTIN)

(Admitted Aug. 7, 2014)

EXHIBIT
P-230
1:14-CV-284-LY

From: Vincent M. Rue <vincerue@bellsouth.net>
Sent: Friday, June 27, 2014 1:55 PM
To: 'Peter Uhlenberg'
Subject: RE: REBUTTAL REPORT

Peter-

Well done! I like your additions Peter. Is there anything you can say about how the number of abortions in ASCs have increased long in advance of the passage of HB2 in 2013? I realize the percent provided in 2012 is down by 1.4% from 2011, but the trend (minus whatever happened in 2009) is pretty clear across 7 years. Also, perhaps you could avoid using 2012 data as it has not been uploaded yet to the DSHS website? What do you think?

Vince

-----Original Message-----
From: Peter Uhlenberg [mailto:uhlen@email.unc.edu]
Sent: Friday, June 27, 2014 12:59 PM
To: Vincent M. Rue
Subject: Re: REBUTTAL REPORT

Vince,

Here is my revised report. Your edits were helpful, and I added two new paragraphs (7 and 14), following your suggestions. I did not add comments on poor women obtaining abortions because I don't think that we have info on whether poor women are less likely to abort if cost increases (which is the question). Also I did not comment on the increasing share of abortions occurring in ASCs, because the share dropped in 2012. I think that could be used against us.

I am, of course, happy to make changes that the AG might want, or if you have further ideas.

Best,

Peter

On 6/26/2014 5:21 PM, Vincent M. Rue wrote:
> Peter -

> Thank you very much for your expedited review of Plaintiffs' reports and assembling this excellent rebuttal report so quickly. Greatly appreciate it.

> I made some small edits, and suggested a few paras you might consider adding/rewriting. The articles I referred to are attached as well as the rebuttal report with my tracked changes. Para 2 is fine.

> Thank you again Peter. I only give you the toughest assignments!

> Vince

>-----Original Message-----
> From: Peter Uhlenberg [mailto:uhlen@email.unc.edu]
> Sent: Thursday, June 26, 2014 12:32 PM
> To: Vince
> Subject: REBUTTAL REPORT

> Vince,

> Here is a draft. (You sent me two tough expert reports to criticize).

> Could you make any editorial changes using track changes?

> You will see in paragraph 2 my questions about what how to indicate the complaint I am responding to. > If you think there is something more that I should cover, let me know.

> Best,

> Peter

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS (AUSTIN)

(Admitted Aug. 7, 2014)

EXHIBIT
P-063
1:14-CV-284-LY

[LOGO] Foundation Surgical Hospital *of El Paso*		**Intranet Reference/ID**
Department/ Function: Medical Staff	**Policy Number:**	**Policy Title:** Privileges
Effective Date: 7/12 **Revision Date:** 9/12	**Originator:**	**Approval:** MEC: 9/11/12 Board: 9/18/12

PURPOSE: Every practitioner practicing at this hospital by virtue of medical staff membership or otherwise, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him by the Governing Board. These privileges define the scope of patient care service that they may provide independently in the hospital.

POLICY: Every initial application and reapplication for staff appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant. The Professional Standard Committee will make the recommendation regarding the

requested privileges to the Governing Board for final action.

Periodic re-determination of clinical privileges and their increase or curtailment shall be based upon the direct observation of care provided, review of the care of the patients treated in this and other hospitals, the number of individual procedures performed or types of cases cared for, the finding from the quality improvement program which provides ongoing monitoring and evaluation of individual's current clinical competence, and the health status of the individual applying for privileges an peer recommendations.

The limitations on the individual's privileges to admit and treat patients or direct the course of treatment for the condition for which the patients were admitted are specified.

All delineation of privilege forms are hospital specific and will be reviewed periodically. These forms will be forwarded to the Professional Standards Committee and the Governing Board for final approval.

End of Policy and Procedure

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS (AUSTIN)

(Admitted Aug. 7, 2014)

EXHIBIT
P-232
1:14-CV-284-LY

From: Vincent M. Rue
To: John Thorp'
Sent: 6/17/2014 9:51:58 PM
Subject: TX case
Attachments: Fine Expert Report 6-16-14.pdf; Grossman Expert Report 6-16-14.pdf; Raymond Expert Report 6-16-14.pdf

John—

Hope your meeting with Harold went well today.

Just thought I would give you an update on the TX case. After getting all the expert reports ready to roll yesterday, the TX AG elected strategically to not submit them and instead to use revised versions of them as rebuttal reports. I was more than surprised. There are advantages for us in not producing these expert reports as this allows us to let plaintiffs' experts be identified first, and then find out what they are opining. Drs. Fine and Raymond continue as experts for Plaintiffs. They added Grossman as well. I am attaching their expert reports for your review. The deadline for submission of our rebuttal reports is June 30.

So may I ask you to please review the attached and see if there is anything you would like to add/subtract from your previously "finished" report?

One other last question. I am concerned we are asking you to shoulder too big of the medical load here. Who else do you know that we could perhaps impose on them to assist in testifying along with you? I wondered about Dr. John Seeds, Dr. Kathryn Hartman or anyone else you might suggest. Your thoughts?

Thanks John.

Vince

[LOGO]

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH, et al.,	)	
Plaintiffs,	)	Civil Action
DAVID LAKEY, M.D. Commissioner of Texas Department of State Health Services, et al.,	)	No. A14CV0284 (Submitted Aug. 11, 2014)
Defendants.	)	

DEPOSITION OF GEOFFREY KEYES, M.D.
Los Angeles, California
Monday, July 21, 2014

Reported By:
SUSAN A. SULLIVAN, CSR #3522, RPR, CRR
JOB NO. 82290

* * *

[26] [MS. TOTI] So during what period of time approximately did you have privileges at Cedars-Sinai?

A 'til about I think—I came out here in 1988 and I had them until about I want to say four years or five years ago.

Q So maybe until about 2009 O 2010?

A I have to look that up. I wasn't using the [27] hospital much at all so it wasn't—it was there for me. Usually the only reason I ever take a patient to the hospital is an emergency unless I was doing a reconstructive case that you shouldn't do as an outpatient.

Q Okay. So did you relinquish those privileges or did the hospital tell you that you no longer met the criteria for privileges?

A Well, I relinquished the privileges because they were telling me I would no longer—I had not done enough cases there.

Q So Cedars-Sinai has a minimum patient admission requirement; is that correct?

A Yes. Minimum patient encounter requirement. I think they consider different things as fulfilling that criteria.

Q Okay. So you don't necessarily have to admit a patient to fulfill the criteria?

A I think if you are called in on consultation that counts as—you know, somebody said I would like you to take a look at this patient and give your advice about it I think that would count, doing a procedure would count, encounter of some sort.

Q Do you recall how many patient encounters you had to have at Cedars-Sinai in order to meet the [28] hospital's requirements?

A I think it was 24 over two years.

Q Okay. And back in 2009 or 2010 approximately you hadn't had a sufficient number of patient encounters within a two-year period to meet that requirement; is that right?

A Right. Because I was using another hospital which was more convenient for me so I was on staff, in the old days you might be on the staff of three or four hospitals. One may be your primary hospital but you would go and see patients at other hospitals too. Cedars-Sinai was no longer really my primary hospital, Olympia was, and then that faded too for the same reasons.

Q Okay. And so did you say you gave up your privileges at Olympia Hospital also because of a minimum patient encounter requirement?

A Yes.

* * *

[36] Q So for some issues you might see the patient yourself and for some issues you might refer the patient to a colleague; is that right?

A Right. In certain circumstances, yes.

Q And the colleagues to whom you might refer a patient in this circumstance, what is your relationship with them?

A They're other board-certified plastic surgeons who I have a collegial relationship with, don't know them well, not friends, but colleagues.

Q Have you ever had to instruct a patient to go to an emergency room?

A Yes.

Q Can you recall a specific example of that or most recent example?

A I had a patient I instructed to go to the [37] emergency room, I don't know time, I'm not real good at how long ago those things happened, but I always tell patients if you have a cough and pain after surgery call me immediately and that's what happened with her and it turned out to be nothing but the concern was potential for pulmonary embolism so—you know what a pulmonary embolism is?

Q Why don't you tell me just so we're sure.

A Pulmonary embolism is—belongs to the broad category of VTE or venous thromboembolism and they're blood clots that usually occur in the calf or in the pelvic region and they're associated first of all with a familial predisposition, clotting factor problems, surgery, extensive air travel, dehydration, these things can cause it But if the blood clot breaks off from its location it can travel through the venous system into the lung and you can die from it because it shuts off oxygenation. So if you suspect something that's going on of that nature you must have somebody look at it right away.

Q Okay.

A I have written papers about it, I never had one, knock on wood, I hope I never do.

Q I hope so too.

[38] A It is terrible, a horrible thing.

Q So in that instance where—do you recall where the patient resided? Was she in the Los Angeles area or the Bakersfield area or somewhere else?

A I'm trying to remember. It might have been Bakersfield but I don't remember for sure. I'd have to look at it. Nothing came of it so it is not something that sticks in my mind.

Q Okay. Do you recall if you traveled to the emergency room to meet the patient there?

A No, it wasn't necessary.

Q Why wasn't it necessary?

A Because her symptoms and problems were related to anxiety.

Actually it was here, it wasn't Bakersfield, I do remember. Her symptoms were related to anxiety and not—you know, you suspect the worst and hope for the best and it was the best, anxiety.

Q How did you—how did you come to know that it was anxiety?

A Because the emergency room doctor took a look at her and he didn't feel that she had—you know, things I couldn't tell over the phone, he could tell in

person measuring her oxygen [39] saturation, examining her, that type of thing.

Q So you communicated by phone with the emergency room physician?

A Uh-huh. A couple of times.

Q And do you recall if that emergency room was at a hospital where you had admitting privileges?

A I don't think it was.

Q In terms of your ability to communicate with an emergency room physician on a matter like this does it matter whether or not you have admitting privileges?

A No.

Q And did you feel like in that circumstance your patient experienced an adequate continuity of care between you and the emergency room physician?

MR. LIONBERGER: Objection; form.

THE WITNESS: So when you do that should I answer or not?

MR. LIONBERGER: You may answer.

THE WITNESS: Yes, I do. The point of the matter is she didn't have a pulmonary embolism so the continuity of care was nothing happened so it was a good communication and a good outcome so it was fine.

* * *

[60] Now I don't know—ambulatory surgery center in reality means that it is a place where surgery is provided and you ambulate, it is not—there's nothing magic about an ambulatory surgery facility. In other words, my office-based surgery center was an ambulatory surgery center. There are some people who choose to look at the structure of the building and make a determination based on that but the care provided is the same, standards are the same, it is really no different.

Q So is it your opinion that the construction standards that serve to distinguish ambulatory surgery centers from other office-based practices are not relevant to the quality of the care that's [61] provided in the facility?

MR. LIONBERGER: Objection; form.

THE WITNESS: That's right. But I'll answer that for you. Let's take the firewall requirement by—that you have to have X thickness of firewall. That standard came from really nursing homes where if there's a fire you had to evacuate a hundred people. Well, it doesn't really totally apply if you have one person in an operating room and the evacuation really may or may not need that thickness of a firewall and this is just one example. But that doesn't mean it is not a regulation under Medicare or maybe for an ambulatory surgery center. So the construction—is

the construction of a firewall helping you provide better surgical care? I'm not sure that's true. I mean, there are so many different roads you can travel in this discussion about—it is really a matter of looking at standards and what the standards are.

If you look at AAAASF standards for office-based facilities or for ambulatory service centers they're pretty comprehensive, they have even been called the gold standard. As a matter of fact, AAAASF helped Medicare develop some of their outpatient standards.

[62] Q BY MS. TOTI: So if we could just for a moment take a look at Paragraph 26 of your expert report, it says, "In light of the significant increase in the number of ASCs and the many benefits they provide the nation's healthcare system, it is medically reasonable that this high standard of care should now be the accepted standard for facilities which provide abortion services in Texas."

Did I read that correctly?

A Yeah, that's reasonable.

Q So when you talk about the many benefits they provide the nation's healthcare system, what benefits are you referring to?

A Well, ambulatory surgery care in general has improved, I think improved healthcare dramatically. It has allowed somebody to come in and have a procedure that might be considered relatively minor and not be in a room next to somebody who has a colon about to be resected or has an infection. The incidence of

nosocomial infections in hospitals is far greater than in ambulatory surgery centers and I refer to ambulatory service centers and office-based as the same. I consider them the same, okay? So—so cost/benefit, safety—lower incidence of infection by far in a—versus outpatient [63] convenience. Those are three major things.

Q But in your opinion the construction standards that are associated with ambulatory surgery centers aren't the source of the benefits you refer to in Paragraph 26?

A No. And that's not what I meant to convey here and, as a matter of fact, we touched upon an issue earlier about the different levels of accreditation, A, for local or, you know, minor surgical procedures that have sort—that's a different level of standards than B, C or C-M so I'm saying comprehensively the overview of providing care in a setting of whatever level that conforms to what's accepted for ambulatory surgery centers or outpatient facilities is what I think is a good thing.

* * *

[64] Q And would it be fair to say that this [65] document contains of the current standards for accreditation by AAAASF?

A Yes.

Q And can you tell me a little bit about how these standards are developed?

A Again getting back to the nonprofit nature of AAAASF, we have a committee of surgeons, many of whom are professors, recognized educators who work on this including anesthesiologists and other types of surgeons, and they're constantly upgrading and improving the standards to improve care.

* * *

[66] Q

So if you turn to Page 17, Standard 100.010.030 says, "All individuals using the facility must meet one of the following criteria," and then it goes on and there are three bullets. The first bullet says, "A doctor of medicine certified or eligible for certification by one of the member boards of the American Board of Medical Specialties," and the second bullet says, "A doctor [67] of osteopathy certified or eligible for certification by the American Osteopathic Association Bureau of Osteopathic Specialties."

* * *

A What it means is that somebody has gone through—I'm board-certified in two specialties and what that means is that I first of course went to medical school, then I did a surgical internship, then I did a recognized graduate medical education training programming and a residency, residency of a specialty. Once I completed that then I was eligible to

take my board examination which is usually written and oral and given over the course of a year. So I'm eligible once I pass those tests, I'm certified. So someone might be eligible for a long time and then we look at well, why haven't you taken the boards. So let's say you are a young surgeon, you finish training, you are joining a surgery center and you are currently eligible to sit for your board examination. We allow them to go ahead and start the process.

Q So for purposes of this standard, 100.010.030, a board-eligible physicians satisfies the standard; is that right?

A Yes.

Q Okay. And let's also take a look at the same 100.010.035. I think this is one of the points of contention here.

[69] A Right.

* * *

Q I'm sorry, you are correct, 30 minutes of—so let me read it again so we have it correctly in the record.

"Every physician, podiatrist, and oral and"—

A "Maxillofacial surgeon."

Q Thank you.

—" maxillofacial surgeon operating in an AAAASF-accredited facility must hold, or must demonstrate that they have held, unrestricted [70]

hospital privileges in their specialty at an accredited and/or a licensed acute care hospital within 30 minutes of the accredited facility for all operations that they perform within the facility."

Did I read it correctly that time?

A Correct.

Q Thank you.

So would it be fair to say that a physician who demonstrates that he or she has held hospital privileges in the past doesn't need to hold hospital privileges currently in order to meet this standard?

A It is on a case-by-case basis. It depends why they don't hold hospital staff privileges; in other words, did they lose their hospital staff privileges because of malfeasance or poor practice performance, and it is reviewed by a committee and discussed. But the small answer or short answer to your question is yes.

Q Suppose that a particular physician held hospital privileges in the past and lost them because she was not able to have enough patient encounters at that hospital.

A Uh-huh.

Q Is it possible that that physician could meet the standard without holding current [71] privileges?

A Yes.

* * *

Q BY MS. TOTI: This one is from the Plaintiffs document production and it is P 3469.

So let me represent to you that this document is a letter from a hospital to a physician who had requested an application for admitting privileges at the hospital. The letter says:

"The Medical Executive Committee at Doctors Hospital at Renaissance met and reviewed your request for the release of application for privileges for you and your group. The Medical Executive Committee upheld the recommendation of the Credentials Committee to deny your request for an application for membership and privileges.

"The recommendation was forwarded to the Board of Governors for review and a determination was made not to extend an application for you. Such determination is as authorized under the Bylaws and Rules and Regulation of the Medical Staff for the [72] Hospital. The decision of the Governing Body was not based on clinical competence consideration."

Did I read that correctly?

A Yes.

Q So in a circumstance like this where a doctor is unable to obtain privileges for reasons that are unrelated to his clinical competence—

A Uh-huh.

Q —if that doctor holds privileges at another hospital or has held privileges in the past, would that

doctor be eligible to meet the standard without holding current privileges?

MR. LIONBERGER: Objection; form.

THE WITNESS: The only problem with your assumption is had those privileges been held in the community within 30 minutes of where they're practicing, otherwise yes. So, in other words, if somebody came in from Ohio to Texas and had never practiced in Texas and they wanted to use their Ohio credentials, that might be a problem.

Q BY MS. TOTI: What if—what if the—what if the physician currently held admitting privileges at a hospital in one part of the state and wanted to practice in a different part of the state?

MR. LIONBERGER: Objection; form.

[73] THE WITNESS: I mean, I did just tell you from the standpoint of AAAASF that we look at individual eases and we try to be reasonable. We're not a punitive organization where our attempt is to, you know, promote the best patient care so we look at individual situations on an individual basis.

* * *

[74] Q BY MS. TOTI: So let's go back to the standard for a minute, 100.010.035. The standard uses the phrase "Unrestricted hospital privileges." What do you understand that phrase to mean?

A That they have full admitting privileges and they're able to operate within the scope of their specialty.

Q Are you familiar with the term "courtesy privileges?"

A Yes.

Q What's your understanding of courtesy [75] privileges?

A That you can't operate. You can visit a patient there but you can't provide care.

Q So would holding courtesy privileges satisfy the requirement of unrestricted hospital privileges?

A Not to my understanding, no.

* * *

[76] Would it be fair to say that Section 200 of the AAAASF Regular Standards and Checklist for accreditation of ambulatory surgery facilities sets forth the physical plant requirements that outpatient surgery centers are required to meet in order to obtain accreditation?

MR. LIONBERGER: Objection; form.

THE WITNESS: Yes.

* * *

[77] Q BY MS. TOTI: So would it be fair to say that in drawing conclusions about the medical benefits of the ASC requirement of House Bill 2 you were

focused on the standards adopted by AAAASF and not any other standards that might be embodied in Texas law?

MR. LIONBERGER: Objection; form.

THE WITNESS: I would say yes. I mean, I can also say that, for example, in California the standards for licensure in California have many things that we don't include in our accreditation standards but we are the equivalent of licensure in California so I don't think they're mutually exclusive. But yes, I'm here on the basis of what I understand from AAAASF and our ability to do so in Texas.

* * *

[78] Q So let's take a look at some of these specific standards.

On Page 25 I would like to take a look at 200.020.035. So the standard there says, "The operating room" or "rooms is adequately ventilated and temperature controlled"; is that right?

A Uh-huh, uh-huh.

Q Would you agree that the standard does not set forth specifications for a facility's HVAC system?

A Yes. It does not.

Q It does not, okay.

A A thermometer or thermostat, I should say.

Q And let's take a look on Page 26 at 200.020.055 at the top of the page. That one says, "Each operating room is of a size adequate to allow for the presence of all equipment and personnel necessary for the performance of the surgical procedures, and must comply with applicable local, state, or federal requirements. Additionally, all [79] facilities must have a minimum of four feet (48 inches) of clear space on each side of the operating table to accommodate emergency personnel and equipment in case of emergency, and permit the safe transfer of the patient to a gurney for transport, or facility personnel can physically demonstrate to the surveyor that the emergency criteria as stated before can be met in the operating room space available."

Did I read that correctly?

A Yes.

Q Do you agree that the standard does not require operating rooms to contain a minimum number of square feet?

A Yes, I do. We don't require it.

Q And in your opinion is a minimum square footage requirement for operating rooms necessary to ensure patient safety during outpatient surgery?

A No.

Q Is the standard set forth in 200.020.055 sufficient to ensure patient safety during outpatient surgery?

A Yes.

Q And I should have asked that question about the last one. If we just go back for a second to [80] 200.020.035, "The operating room is adequately ventilated and temperature controlled"—

A Uh-huh.

Q —is that standard sufficient to ensure patient safety during an outpatient surgical procedure?

A I believe so.

Q Okay. So at the bottom of Page 26 there's 200.020.085 and that one says, "If one sink is used both for dirty instruments and to scrub for surgery, there is a written policy to clean and disinfect the sink prior to scrubbing hands."

Did I read that one correctly?

A Yes.

Q So this standard permits one sink to be used both for the cleansing of dirty instruments and for surgical hand scrubbing provided that the specified precautions are taken; is that correct?

A Correct.

Q And in your opinion is that standard sufficient to ensure patient safety for a patient that's undergoing an outpatient surgical procedure?

A Yes.

Q Okay. So I want to turn to Page 27 and take a look at the one at the top, 200.020.090. That one [81] says, "If a preexisting sink is present in the operating room, a written policy to prohibit the use of the sink during sterile surgical procedures must be in place. A sink is permissible in an operating room which is exclusively used for endoscopic or urological procedures in accordance with the standards of those professions. Requests for allowance by other specialties will be reviewed on a case-by-case basis."

Did I read that correctly?

A You did.

Q What is, what is meant by the term sterile surgical procedures in that first sentence?

A A procedure in which a patient is prepped and draped and those involved in the surgical procedure are also gowned and gloved with masks to try to preserve sterility.

Q Are there some surgical procedures that wouldn't fall into that category?

A Yes.

Q Which ones?

A Any colonoscopy-type procedure, vaginal procedures, intraoral procedures, although some people still do some prepping on those but any orifice basically is not sterile, can't be sterile.

[82] Q Okay. So—

A You can use antisepsis but that doesn't mean it is totally sterile.

Q So would it be—would you agree that certain bodily orifices are naturally colonized by bacteria?

A Yes, of course.

Q And is that what you mean when you say they're not sterile?

A Yes.

Q You would still expect a surgeon to use sterile instruments during those procedures, wouldn't you?

A Yes.

Q But—

A No need to add to the mix.

Q But the kinds of sterile precautions that you would take prior to a breast augmentation surgery wouldn't be necessary for the procedures performed in the orifice as you described; is that right?

MR. LIONBERGER: Objection; form.

THE WITNESS: I would have to say that many surgeons will still prep and drape and use, as I said, a prep of some sort, use sterile gloves of [83] course. But no, you can view them differently.

Q BY MS. TOTI: Okay. I just want to go through a few more of these standards quickly.

If we look at on Page 29, 200.040.020 at the top, it says, "The instrument preparation and assembly area (clean utility area) is separated by walls or space from the instrument cleaning area (dirty utility area) or, there is a policy to clean and disinfect the dirty utility area before preparing and assembling packs for sterilization," did I read that correctly?

A Yes.

Q So would it be fair to say as long as there's a policy in place to clean and disinfect the dirty utility area before preparing and assembling packs for sterilization a facility need not maintain separate rooms to function as a clean utility area and dirty utility area?

A That is correct. It is desirable but you don't have to have separate rooms, no, you have to have a barrier room, that's what it means by a barrier, or do what you just said.

Q Okay. And do you think that this standard is sufficient to ensure the safety of a patient undergoing an outpatient surgery?

[84] A Yes. If it is done correctly as prescribed.

* * *

[86] Q One more on this page. 200.040.030. The next one. It says, "Scrub suits, caps or hair covers, gloves, operative gowns, masks and eye protection are used for all appropriate surgery." Did I read that correctly?

A Yes.

Q And I think we have already talked about this a little bit but what is meant by appropriate in that sentence?

A I would hope all surgery is appropriate but for those cases that need to maintain complete sterility, not only to protect the patient but to protect the operating surgeon too. In other words, if you are doing a colonoscopy you don't have to [87] have a gown on if you don't want to. I would prefer to have one on but you don't have to.

* * *

[94] Q Right. But if you are not applying for Medicare and you are just seeking accreditation through AAAASF you can become accredited regardless of the width of your hallways; is that correct?

A That's true. That's correct. And that's correct in Texas too.

* * *

[95] Q And the standards that we're looking at today, the AAAASF Regular Standards and Checklist for accreditation of ambulatory surgery facilities, they don't specify the size and location of janitorial closets, would you agree with that?

A No, they do not.

Q They don't specify the number of parking spaces a facility should have?

A They do not.

* * *

[98] Q Okay. Would you agree that not all ambulatory surgery centers in the U.S. are accredited?

A Yes.

Q Would you agree that not all ASCs in Texas [99] are accredited?

A That I don't know. I think they require accreditation or licensure, one of the two.

Q So do you equate accreditation and licensure?

A Yes. It carries the same exact weight. It means the same thing. It is just that many states are not well equipped to or haven't designated enough staff to work out the licensure process so they deem organizations like JCAHO, AAAASF, to come in and do—we call it accreditation because we're not licensing the license, they issue the license on the basis of the accreditation. Without the accreditation you don't need the license. But in California you don't need to be licensed, my surgery center was never licensed but it was accredited which carried the same weight.

Q But are you aware that in Texas there are some facilities that are licensed directly by the state on the basis of inspections that State Department of Health personnel undertake?

A Same thing as in California, yes.

Q And in your view does that licensure process provide the same kinds of safeguards as the accreditation process that your organization would [100] undertake?

A I would assume so. I mean, I would say in California it does. Some of it is more onerous than our process and onerous doesn't translate necessarily into being better, it is just onerous. But I would assume that Texas has a, you know, responsible licensing system in place but they obviously allowed AAAASF to accredit so it is the same thing.

* * *

[113] So, for example, some abortion providers might provide the full range of OB/GYN care, would you agree?

A Correct, yes.

Q Including delivering babies and performing hysterectomies, would you agree?

A Yes.

Q Would you agree a doctor who delivers babies on a regular basis and performs hysterectomies on a regular basis would have no difficulty meeting a hospital's requirement for minimum patient encounters?

MR. LIONBERGER: Objection; form.

[114] THE WITNESS: I would assume that that would be the case, yes.

Q BY MS. TOTI: But would you agree that there are some doctors that specialize solely in abortion care and don't perform major abdominal surgeries or deliver babies?

A Yes.

Q Including some of the abortion providers in Texas.

A Yes.

Q So just because some Texas abortion providers hold hospital admitting privileges doesn't mean all Texas abortion providers could be able to obtain admission privileges?

A That's true and I think that's what's going on around the country but I think that's an issue with the hospital that needs to be dealt with but yes, I agree with that.

* * *

[117] Q And then at the end of this paragraph you say, "Then too, because most ASCs are physician owned, the quality of care is higher in ambulatory surgery centers because surgeons are invested both clinically and financially in their patients' success."

[118] A That's something that's been said. I think that the most important aspect is they're clinically involved. The financial component means they're more careful about cost expenditures and waste and things of that sort. So I would say it is probably a true statement, I agree with it, having run one.

Q And what is the benefit of being cautious about cost expenditures and avoiding waste?

A Well, you can't operate if you waste. I mean, we had a good look at that with Medicare and what's happened with Medicare. I mean, a lot of expenditure is waste and if you are running a surgery center you have to try to limit the waste so can you operate efficiently.

Q So can you give me an example of what you would think of as waste in this context?

A Using too many four-by-four pads just opening randomly and not, you know, isolating on how many you think you will need for a procedure. I mean, that's just a gross example.

Q Using more surgical supplies than are necessary would be an example?

A Exactly, yeah. Being conservative with how you allocate your resources.

Q But what's the harm in consuming more [119] resources than necessary for a particular procedure?

MR. LIONBERGER: Objection; form.

THE WITNESS: I mean, we can go into a long discussion about that but, I mean, if you are operating a fiscally responsible business, if you use more resources than necessary eventually the costs will escalate so you won't be able to provide service

anymore or you will have to increase the price so much that people can't afford the service.

* * *

[120] Do you see an inherent conflict between a healthcare provider's financial interest in providing medical services and the ethical obligation that the provider has to their patient?

A Only limited by the ethical character of the individual. But no, not inherently, no, no. You have to profit by your work, everyone does.

I would just throw the question to you as an attorney. Do you feel that representing people inherently makes—you want to represent more people unethically because blah, blah, blah? It the same thing. No, not inherently.

Q Okay.

A It doesn't mean that there aren't unethical circumstances that have occurred but I don't think inherently that's the case.

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DIVISION OF TEXAS
AUSTIN DIVISION

(Submitted Aug. 11, 2014)

WHOLE WOMAN'S HEALTH,
et al.,

Plaintiffs,

vs.

Case No:
14-CV-284-LY

DAVID LAKEY, M.D., et al.,

Defendants.

Deposition of
Peter Uhlenberg, Ph.D.
(Taken by the Plaintiffs)
Chapel Hill, North Carolina
July 25, 2014
At 9:45 a.m.

Reported by LeShaunda Cass-Byrd, CSR, RPR
TSG Job No: 82294

* * *

[74] [MR. BROWN] Q. What does "verified" mean as you use it in this sentence here in your report?

A. Verified would be some standard to judge the accuracy of the data.

Q. Is the only way to verify data to check it against other data provided by a government agency?

MR. STEPHENS: Object to the form.

THE WITNESS: I don't know.

BY MR. BROWN:

Q. Are you familiar with any ways to verify data other than to check it against other data provided by a government agency?

[75] A. Yes, in demographic research, we look at internal consistency of the data. We compare it with past records. We can look at how questions were asked, the response rate, the basis for reporting of data.

Q. In your academic research, do you use data that has been verified in any of those ways?

A. Yes.

* * *

[77] Q. Is it your opinion that Dr. Grossman does not rely on any data for his conclusions regarding the number of abortions that occurred in Texas after December 31st, 2012?

A. It's my understanding from his report, that he relies on data that was collected by his organization.

Q. Is that data?

A. Yes.

Q. So when I asked you a moment ago is there any data regarding abortions performed in the State of Texas after December 31st, 2012, does that exclude the data that Dr. Grossman relied on?

A. I should have said other than the data collected by Dr. Grossman's organization.

Q. Okay. So let me ask the question again.

Is there any data available regarding the number of abortions that occurred in Texas for any [78] period after December 31st, 2012?

MR. STEPHENS: Object to the form.

THE WITNESS: Yes.

BY MR. BROWN:

Q. Is there any data available that you are aware of regarding the number of abortions that occurred in Texas after that period other than Dr. Grossman's data?

A. No.

Q. Is there any data available for abortions occurring in Texas after December 31st, 2012, that could be verified using some of the methods that you identified earlier?

A. Yes, I think some of those methods could be used to add confidence that the data are correct.

* * *

[108] So I wanted to ask you what the decline is in the number of abortions as a percentage from 2010 [109] to 2011 and 2011 to 2012. Could you do that with the data that you have in front of you and the data in your report?

A. Yeah. Can you give me a calculator?

So I'm going to use the total Texas residents as my base.

Q. Okay.

A. This is for 2010. And you asked me to look at Paragraph 9?

Q. Paragraph 12 on Page 9.

A. Oh, I got the wrong report.

Q. Okay.

A. So if I did this correctly, it would be a 6.6 percent decline. 2010 to 2011.

* * *

[110] Q. And what is the decrease in 2011 to 2012

A. I came up with 5.6 percent decrease.

Q. Thank you. I can take that back.

[111] Is the decrease in the number of abortions to residents of Texas as a percentage from 2010 to 2011 greater than that found by Dr. Grossman between his Period 1 and his Period 3?

A. I don't know.

Q. Would it help you to look at Dr. Grossman's report?

A. Yes.

Q. If you'd turn to Chart 1 of Dr. Grossman's report, which is Page 17—excuse me—Chart 2, which is Page 18. Does that help you?

A. Yes.

Q. So the question is, was the percentage decrease from 2010 to 2011 that you just told me greater than that found by Dr. Grossman between Period 1 and Period 3?

A. He reports a 13 percent decline from Period 1 to Period 3.

Q. So the one that you found from 2010 to 2011 was less of a decrease?

A. Correct.

Q. And was the period from 2011 to 2012 that you also reported to me less of a decrease?

A. Yes.

[112] (Plaintiffs Exhibit 9 was marked for identification.)

BY MR. BROWN:

Q. Do you recognize this article, Dr. Uhlenberg?

A. Yes, I have seen this.

Q. And is this the article Abortion Incidence and Service Availability in the United States, 2011, that you cite in your report?

A. I guess I would need to check.

Q. If you look at Paragraph 11, I believe you will see a cite of that.

A. Yes.

Q. Can you look at the third page of the article? I guess it's Page 5. Under results in the bottom right.

A. Yes.

Q. It says in the first sentence: The number of abortions and the abortion rate declined steadily between 2008 and 2011, about 4 to 5 percent per year. Did I read that correctly?

A. Yes.

Q. Do you have any reason to disagree with that statement?

[113] A. No.

Q. And on the following page it says: The number of abortions and the abortion rate both decreased 13 percent between 2008 and 2011.

Did I read that correctly?

A. Yes.

Q. And do you have any reason to disagree with that statement?

A. No.

Q. And this article covered the period between 2008 and 2011; is that correct?

A. Correct.

* * *

[117] Did the authors of this article rely on data about abortion patients reported to them by abortion providers?

A. Yes.

Q. Did the authors of this study rely on estimates of the number of abortions performed from knowledgeable sources when they were unable to obtain patient numbers from abortion providers?

A. Yes.

Q. Did the authors of this study make their own estimates regarding—for patients at facilities for which they had neither provided reported numbers nor estimates from knowledgeable sources?

[118] A. Yes, in some cases.

* * *

[121] Q. Do you believe that if the price of abortion goes up, that the quantity of abortions demanded will go down?

MR. STEPHENS: Object to the form.

THE WITNESS: That is a debated issue in the literature. It refers to whether—the elasticity of demand. For some goods, the demand will remain constant with the increase in cost, and whether that is the case for abortion or not, there's disagreement in the literature.

BY MR. BROWN:

Q. Do you have an opinion about that question?

A. I expect that within the ranges we're talking about, it's quite—the demand is quite inelastic.

Q. When you mean "quite inelastic," do you mean completely inelastic?

A. No.

* * *

[132] Q. Okay. Do you know whether the number of abortions at or after 16 weeks in Texas—I should say performed on Texas residents in Texas, ever returned to its pre-2004 level?

A. I think it did not.

* * *

[134] Q. In Paragraph 16 of your report, you say that statewide demand for abortions at or after 16 weeks in Texas in 2003 was fewer than 4,000; is that correct?

A. Yes.

Q. What is the basis for that statement?

A. That in preceding years, there had never been as many as 4,000 late-term abortions performed it Texas on Texas residents.

Q. And by "late term," you mean at or after 16 week gestation—

A. Correct.

Q. —is that correct?

And so the figures that we read from the chart for the three years preceding 2004 were all [135] under 4,000; is that right?

A. Right.

Q. But over 3,000?

A. Right.

Q. Okay. Does this article state how many abortions at or after 16 weeks were performed in Texas for Texas residents in 2006?

A. Yes.

Q. And how many is that?

A. 1,454 is reported.

Q. And are you looking at the chart on Page 785?

A. Yes.

Q. Okay. And you say that by that time, four ASCs had been built to meet the demands for abortions at or after 16 weeks in Texas; is that correct?

A. Correct.

Q. Did those four ASCs perform over 3,000 abortions at or after 16 weeks in Texas in 2006?

A. No.

* * *

[147] Q. Do you have an opinion as to whether there is any relationship between a woman's distance from an abortion provider and the likelihood that she will have an abortion?

A. Well, the research tends to show that abortions rates for women living further from an abortion provider are lower than those living near an abortion provider.

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH, et al., Plaintiffs, vs. DAVID LAKEY, M.D. Commissioner of Texas Department Of State Health Services, et al., Defendants.	Civil Action No. A14CV0284 (Submitted Aug. 11, 2014)

DEPOSITION OF MAYRA THOMPSON, M.D.
Dallas, Texas
Monday, July 14th, 2014

Reported by:
Daniel J. Skur, Notary Public and CSR
Job No. 82283

[37] [MS. TOTI] Q. Could you typically use aspiration for the curettage part of the procedure, or do you use sharp curettage?

A. Generally sharp.

Q. Can you, just for the record, describe the difference between those two methods?

A. Suction—sharp curettage uses a curette which has a sort of a rounded tip. It has a sharp tip that may or may not have the little teeth for—that look like a rake, and that's passed in, and what you

do is you just—like you would rake anything else, you bring it against the tissue, and you bring the sample out, and that's called sharp.

For suction curettage, what you would do is you dilate the cervix again to allow the size of the tip to go into the uterus. The sharp curette is generally 5 millimeters at the shaft and can range anywhere from, I think it's somewhere between 6 or 8 millimeters at the tip and can get a lot bigger to almost two centimeters depending on the size [38] of the curette. Once that is determined, the size that you're going to do, that's the size that you would dilate. For most D&Cs, the smaller ones are more than adequate.

In a suction curettage, you have to use a plastic tip suction curette which is either straight or is curved. They range in size, again, from about I think it's 6 to 7 millimeters all the way up to the very large, almost 18, 20 millimeters and could be even bigger. The cervix is dilated to that, and it's passed into the uterus, and it's placed in the uterus and attached to a hose that is attached to a machine that creates suction. Once it's passed, the machine is turned on, and the—that is used to pretty much vacuum out the tissue.

Q. So I think I had used the term "aspiration" and you used the term "suction," but do you understand those two terms to be describing the same procedure?

A. Yes, approximately.

Q. And why is it that you generally use sharp curettage rather than suction curettage?

[39] A. Most of the cases that I do, I'm doing for diagnostic or therapeutic, and they are generally in patients that are not pregnant.

Q. So suction curettage would be more common in pregnant patients?

A. Yes.

Q. And why is that?

A. Many times, pregnancies are—they end in miscarriages and they have retained products of conception, and that's the technique used for that.

Q. And can you say why, what is it about the pregnancy that makes that method more preferable?

A. The tissue is softer and more easily perforated.

Q. And sharp curettage is more likely to result in a perforation; is that correct?

MR. STEPHENS: Object to the form.

A. Yes.

BY MS. TOTI:

Q. And just to be clear, when we're talking about perforation, we're talking about [40] perforation of the uterus?

A. Yes.

* * *

[47] Q. Does your hand make contact with the patient's vagina at any point during the procedure?

[48] A. Well, yes.

Q. And it's impossible to fully eradicate bacteria from the vagina; isn't that correct?

A. Well, true. That's true.

Q. So your hands necessarily become contaminated as soon as they make contact with the patient's vagina; isn't that correct?

A. Say that again, please?

Q. Your hands necessarily become contaminated as soon as they make contact with the patient's vagina; isn't that correct?

A. I don't agree with your term "contaminated."

Q. What term would you use?

MR. STEPHENS: Object to the form.

A. It doesn't apply here.

BY MS. TOTI:

Q. Once your hands make contact with the patient's vagina, they are no longer sterile; is that correct?

A. I don't agree with that statement.

Q. So it's your expert opinion that your hands remain sterile after coming into [49] contact with the patient's vagina.

MR. STEPHENS: Object to the form.

A. I don't agree with that comment either.

BY MS. TOTI:

Q. Why don't you agree with it?

A. When I do a procedure in the vagina, I follow a proper cleaning technique which is called the preparation, scrubbing of the vagina, and it is at that point considered clean for the purpose of that procedure. Once I have scrubbed and I'm appropriately gowned and the patient is draped, I have followed the proper protocols for maintaining an aseptic field, and that has been the condition where I now do not consider myself contaminated when I touch the vagina.

Q. So you operate under the belief that it's possible to make the vagina aseptic?

A. It's considered aseptic, yes.

* * *

[56] Q. Are you familiar with the term "call partner"?

A. Yes.

Q. What does that term—what do you understand that term to mean?

A. In my practice, a call partner is a person that you share a practice with, either an actual member of your same group or, in a situation where you are in solo practice, a partner that you have a prearranged agreement to have a rotation to cover each other when you're out of town or when you are just—let's say you have a rotation to cover certain weekends on a predesignated schedule to have time off, so someone that perhaps you operate with regularly or share an office space with regularly. There's a lot of different scenarios where you have a very close known working relationship.

Q. So in the event that you are out of [57] town or unavailable and an issue came up with one of your patients, you would refer the patient to your call partner; is that right?

A. Generally the call partner takes that call for me, yes.

Q. Is that considered patient abandonment?

MR. STEPHENS: Object to the form.

A. No.

BY MS. TOTI:

Q. Why not?

A. Because it is a person that is intimately part of my practice, and that person is my designee to take care of the patient.

Q. Why is there a need for a physician to have a call partner?

A. A physician needs to have someone to back him or her up in the event of their unavailability.

Q. Because a physician can't be available 24 hours a day; is that right?

A. Yes.

* * *

[95] Do you have any opinion on whether the methods used by the Texas Department of State Health Services to collect data on maternal mortality are reliable?

A. I believe they're reliable.

Q. Do you have any reason to doubt the accuracy of the data collected by the Texas Department of State Health Services about maternal mortality?

A. No.

Q. Would you agree that pregnancies ending in abortion are substantially shorter than those ending in childbirth?

A. Yes.

Q. Are you aware of the gestational limit on abortions in Texas?

A. Yes.

Q. What is the gestational limit?

A. 20 weeks.

Q. And what is the length of a full-term pregnancy?

A. 40 weeks, plus or minus two.

Q. Would it be fair to say that when you measure a pregnancy from the first day [96] after a woman's last menstrual period, the duration of the pregnancy is 40 weeks?

A. Yes.

Q. And that measure of gestational age is often referred to as LMP?

A. The measure of gestational age?

Q. So it would be 40 weeks LMP; is that correct?

A. From the LMP.

Q. Right. Okay. And if you measure a pregnancy from the expected time of fertilization, it would be 38 weeks; is that correct?

A. Correct.

Q. So LMP is two weeks longer, right?

A. Yes.

Q. Would you agree that the longer a pregnancy progresses, the more time there is for a complication to develop?

A. Yes.

Q. Would you agree that many serious pregnancy-related complications don't develop until late in pregnancy?

A. Say that again.

[97] Q. Would you agree that many serious pregnancy-related complications would not present themselves until late in pregnancy?

A. Many, yes.

* * *

Q. And why would healthcare practitioners want to reduce the Cesarean section rate?

[98] A. Number of reasons. Probably—I'm going to name a few, but it's not limited to the few I'm going to name. One of which is reduction of infection, reduction of future possible complications, also to decrease the incidence of postoperative adhesions for the patient and lots—lots of health benefits.

Q. So would you agree that women who have Cesarean sections are at higher risk of complications than women who have natural childbirth?

A. Yes.

* * *

[100] Q. So is it your opinion that younger and healthier patients are at less risk for abortion-related complications than other patients?

A. Yes.

Q. And why is that?

A. Patients who are healthier don't have perhaps medical complications such as diabetes or other types of illnesses that could create—or perhaps be on medication that could complicate an abortion or elective procedure are going to fare better in general than patients who do have them. It's just a known medical fact.

Q. And is that generally true with respect to all medical procedures?

A. Yes.

* * *

[137] Q. Would you agree that some surgical procedures do not entail a sterile operating site?

A. Yes.

Q. Is the alimentary canal sterile?

A. No.

Q. Is the respiratory tract sterile?

A. No.

Q. Is the vagina sterile?

A. No.

Q. The vagina is naturally colonized by bacteria, correct?

A. Yes.

Q. I've seen some textbooks refer to it as microflora which might be a nicer way of saying it, but would you agree that different types of surgeries require different levels of sterile precautions?

A. Yes.

* * *

[139] Q. How is the term "office-based surgery" defined in this document? I believe that the definition is on page 7.

A. That's correct. Page 7, number 21.

Q. Okay. And would it be fair to say that under the definition of office-based surgery in this document, surgery performed in a clinic as well as surgery performed in an ambulatory surgery center would meet the definition?

A. Yes.

Q. So—so the guidelines for office-based surgery don't distinguish between clinics on the one hand and ASCs on the other. Would that be fair?

A. Yes.

Q. It lumps them all together?

A. Yes.

* * *

[140] Q. Okay. Let me ask the question [141] another way. Is there anything in these guidelines that suggests that major surgery may only be performed in an ASC or in a hospital?

A. Level 3 office services is a procedure which requires—that section in section 2, what they're doing here is they are giving you different levels of care in an office, and what they're basically saying is that a level 3 office procedure is essentially—has to meet similar requirement to an ASC. Okay? And they're not going into details necessarily, but these—these places have to be accredited by an agency that won accredit—that would require the same or similar requirements as an ASC.

* * *

[142] Q. Okay. So under these guidelines, it's possible for an outpatient facility that is not an ASC to meet the standards for level 3 offices; is that correct?

A. Yes.

[143] Q. Okay. Do these guidelines mandate that an operating room meet a minimum square footage requirement for any level of procedure, 1, 2, or 3?

A. I don't believe they go into that detail, but let me confirm it.

Q. Sure.

A. Yeah, I don't think they go into that detail, square footage. I didn't think so.

* * *

[144] Q. And these guidelines on their face do not mandate the minimum width of hallways for any level of office; is that correct?

A. Right.

Q. And these guidelines don't include any requirements concerning the layout and traffic flow throughout a facility for any level of office; is that correct?

A. That's correct.

* * *

[145] Q. Okay. Okay. Under these guidelines, would you agree that D&Cs performed under minimal or moderate sedation would be classified as level 2 office procedures?

A. I consider it a level 3.

Q. Why is that?

[146] A. Because I feel that a D&C has potential for complications that may require further surgical procedures to be performed in order to treat it, and I would like to have that available to me at the time of the procedure, and patients undergoing the D&C have the potential of having a lot of pain based on the nerve fibers located in the uterus, and many times, they require deeper form of sedation than what would

be covered in a level 2, and, therefore, I would consider it a level 3.

Q. Sure. So if a patient undergoing a D&C has a deeper level of sedation, then the D&C would certainly be a level 3 procedure, but if the D&C is performed under minimal or moderate sedation, it would be a level 2 procedure, correct?

A. No.

Q. Isn't it true that every surgical procedure entails a risk of complication?

A. Yes.

Q. And isn't it true that every surgical procedure could require a follow-up [147] procedure if something goes wrong?

A. Yes.

Q. So what is it about D&Cs specifically that in your opinion takes it out of the level 2 strata and puts it in the level 3 strata?

A. A D&C is a procedure where you—where a lot of the actual procedure is performed blindly. You're going into a cavity, and you're doing the procedure by feel and not by seeing, it's by feel and touch, and even though it can be very safe in a controlled situation with good anesthesia, it has the potential of having significant complications, and if you fail to understand that you can have a complication that could—that could be avoided, and, therefore, I believe that it

differs from a lot of the other procedures that can be done in a level 2.

* * *

[152] Q. Would you agree that medical abortion is not a form of surgery?

MR. STEPHENS: Object to the form.

A. By "medical abortion," do you mean administration of medication, or what do you mean by "medical"?

BY MS. TOTI:

Q. Yes. By medical abortion I mean an abortion that's induced through the administration of medications.

A. Yes.

Q. So these guidelines wouldn't apply at all to offices where medical abortions are performed; is that correct?

A. No.

Q. No, that's not correct, or no, the guidelines wouldn't apply?

A. The guidelines would not apply.

* * *

[154] Q. So for purposes of emergency transfer of a patient, these guidelines do not require a physician

to have admitting privileges at a local hospital, correct?

A. No.

Q. No, the guidelines don't require it, or no, it's not correct?

A. No, they don't require it.

* * *

[155] Q. Under this guideline, if a physician is able to document board certification, board eligibility, formal training, or experience, the physician does not need to have hospital admitting privileges; is that correct?

[156] MR. STEPHENS: Object to the form.

A. For level 2, yes.

BY MS. TOTI:

Q. Okay. And then let's check the corresponding standard for level 3 office procedures on pages 14 and 15. Starts at the bottom of 14 and carries over to 15. Does standard 3A say anything in addition about hospital admitting privileges?

A. Does not require.

* * *

[165] Q. What does ACOG stand for?

A. American College of Obstetricians and Gynecologists.

Q. And what is ACOG?

A. It's an association, professional association, that the majority of the practicing OB/GYNs belong to.

Q. So do you consider ACOG to be a reliable source of information about obstetrical and gynecological procedures?

[166] A. Yes.

* * *

[169] Q. Okay. Okay. Let's turn back to your report. I'm going to look at paragraph 12 now. Paragraph 12 starts out: Elective abortion for the termination of pregnancy is considered no less safe than a diagnostic or therapeutic D&C. It has comparable risks to the suction curettage for retained products of conception in a miscarriage.

Did I read that correctly?

A. Yes.

Q. Is that an accurate statement of your opinion?

A. Yes.

* * *

[174] Q. What if the out-of-state abortion provider had a call partner that was located in state?

A. That would not be consistent with what I defined as a call partner before.

[175] Q. Why not?

A. Because that person would not necessarily be intimately involved with that doctor as a—as a partner. It would just be a courtesy or cursory relationship, and I don't think that that is truly a call partner.

Q. Well, what is that assumption based on?

A. It's based on the distance, because if you're coming in from out of state and you're not involved with the—that doctor on a day-to-day basis or at least on a weekly basis, you don't have that relationship that v. truly consider a partner.

Q. But what if—what if a provider did have that relationship with another doctor?

A. It would be—it would probably be okay, but it would be difficult to establish that relationship.

Q. Why?

A. Because if you're not residing in the state with that other and practicing at least in the same location the majority of the time, you're not a partner. You're just a [176] associate that's a distanced associate. That's not a partner.

* * *

[181] Q. So for purposes of establishing a physician's credentials, the geographic location of the hospital is not a relevant factor, correct?

A. Correct.

* * *

[220] Q. Would you be in favor of a law that required all physicians, regardless of their area of specialty, to have admitting privileges at a hospital within 30 miles of each location where they practice?

A. No.

Q. Why not?

[221] A. Because a family practitioner may not need to be—if the family practitioner has, for example, is—or a GP may be just taking care of office-based practice and does not perform any surgeries and is able to then be the first-line triage and transfer patients or at least direct them to an office—I mean to a hospital-based facility.

Q. But wouldn't admitting privileges requirement serve a valuable credentialing function for those physicians?

A. It would, but it shouldn't be a requirement.

Q. Well, what's the harm?

A. If a physician is licensed and their practice does not require continuity of care to that degree, like a surgeon does, there might be a benefit, but it may not be necessarily a requirement.

Q. Well, how often does a physician have to transfer a patient's care to a hospital-based setting for an admitting privileges requirement to be warranted, in your opinion?

[222] MR. STEPHENS: Object to the form.

A. It depends on the medical condition that is being treated. If you're treating outpatient high blood pressure, it's rare that you need to transfer to a hospital facility. If your family practice or your general practice is one that you're just doing preventative care, maybe immunization therapy, perhaps the only time you would send somebody is in the case of an allergy, in which case that could happen anywhere.

BY MS. TOTI:

Q. But if you are providing primary care services, you are responsible for facilitating all medical interventions that your patient needs; isn't that correct?

A. Facilitating means making a phone call to get a, I don't know, consultation, then in that regard, yes, you are facilitating. But it doesn't mean you need hospital privileges for that.

Q. But suppose you're a primary-care physician and your patient needs gallbladder surgery, wouldn't there be better continuity of [223] care if you as the primary-care physician had admitting privileges at the hospital where the gallbladder surgery was going to be performed?

A. You don't know the patient has a need for gallbladder surgery if you're a general practitioner. You may know the patient has pain after eating. You may know the patient has other symptoms, but you may not know that this is the situation. In which

case, if you have a condition that falls outside of your normal level of expertise, you then refer to the person who has—the specialist who has that level of expertise, and then that person makes that diagnosis and then follows up, and that has established a continuity of care because you discovered a situation that is—the diagnosis falls out of your area to manage, and you've transferred appropriately.

Q. But how does the specialist get all the information about the patient's medical history if the primary-care physician doesn't have admitting privileges at the same hospital as the specialist?

[224] A. By the transfer of the medical records.

Q. That's sufficient continuity of care, in your opinion?

A. Well, there's usually—if you were referring the patient to the doctor, you're sending the medical records and generally sending a letter or making a phone call to establish—to notify the specialist.

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH, ET AL.,	§	
Plaintiff,	§	CIVIL ACTION
VS.	§	A14CV0284
DAVID LAKEY, M.D. COMMISSIONER OF TEXAS DEPARTMENT OF STATE HEALTH SERVICES, ET AL.,	§	(Submitted Aug. 11, 2014)
Defendants.	§	

ORAL DEPOSITION OF KATHRYN PERKINS
JULY 25, 2014
HIGHLY CONFIDENTIAL—
ATTORNEYS' EYES ONLY

ORAL DEPOSITION OF KATHRYN PERKINS, produced as a witness at the instance of the Plaintiff and duly sworn, was taken in the above styled and numbered cause on Friday, July 25, 2014, from 1:21 a.m. to 6:29 p.m., before Tamara Chapman, CSR, RPR in and for the State of Texas, reported by computerized stenotype machine, at the offices of O'Connell Soifer, 98 San Jacinto, Suite 540, Austin, Texas, pursuant to the Federal Rules of Civil Procedure and any provisions stated on the record herein.

Job # 82595

* * *

[6] KATHRYN PERKINS, having been first duly sworn, testified as follows:

EXAMINATION

BY MR. O'BRIEN:

Q. Good afternoon, Ms. Perkins. Could you please state your full name for the record?

A. Kathryn Perkins.

Q. What's your current employment?

A. I am the assistant commissioner for regulatory services.

Q. And you're the assistant commissioner for regulatory services at the—

A. At the Department of State Health Services, yes.

* * *

[8] (Exhibit 1 was marked.)

MR. O'BRIEN. I'm going to provide the witness what is marked as Exhibit 1, which is the Amended Notice of Deposition of the Texas Department of State Health Services.

Q. (BY MR. O'BRIEN) Are you familiar with this document, Ms. Perkins?

A. Yes, I am.

Q. Have you reviewed it in advance of this deposition?

A. Yes.

* * *

You are here to testify on behalf of the Department. Correct?

A. Yes.

Q. And you are here to testify on behalf of the Department as to specific topics that we have identified with your counsel. Correct?

A. Yes.

Q. And your counsel put those on the record. Correct?

A. Yes.

[9] Q. You understand that your testimony with respect to these topics may bind the Department?

A. Yes.

* * *

[12] Q. So you indicated you are the assistant commissioner for regulatory services.

How long have you held that position?

A. Seven and a half years.

* * *

[13] Q. Going back to your current position as assistant commissioner for regulatory services, what are your responsibilities at a high level?

A. I have responsibility for somewhere between 70 and a hundred programs within five regulatory strategies: food and drug; environmental health; radiation control; healthcare professions and healthcare facilities; and one nonregulatory strategy, EMS trauma systems.

We license—we issue licenses, we do compliance activities, which includes complaint investigations, surveys, inspections, sampling like of meat and milk and we take enforcement actions if there is—say we find deficiencies on an inspection, that they're not following the rules or the law, we can take enforcement action depending on what the statute allows.

All my programs are statute based.

Q. Who do you report to?

[14] A. The commissioner of health.

Q. Who is that?

A. Dr. David Lakey.

* * *

[15] Q. Before we get started, I just want to make sure we are clear on a few terms that we're going to use today and make sure you understand what I'm referring to.

When I refer to "D-S-H-S" or "DSHS" or "the Department," I'm referring to the Department of State Health Services.

Do you understand that?

A. Yes.

Q. When I refer to "the admission privileges requirement," I'm referring to Section 171.0031 of the Texas Health and Safety Code which requires that a physician performing or inducing an abortion must, on the date the abortion is performed or induced, have active admitting privileges at a hospital that is located no further than 30 miles from the location at which the abortion is performed or induced.

Do you understand that?

A. Yes.

[16] Q. When I refer to "the ASC requirement," I am referring to Section 245.01(a) which states that the minimum standards for an abortion facility must be equivalent to the minimum standards adopted under Texas Health and Safety Code Section 243.01 for ambulatory surgical centers.

Do you understand that?

A. Yes.

Q. And when I refer to "ASC," I'm going to ambulatory surgical centers.

Do you understand that?

A. Yes.

Q. When I refer to "Texas House Bill No. 2" or "House Bill No. 2," I'm referring to the Act passed on July 18th, 2013, which included the aforementioned

admissions privileges requirements and the ASC requirement.

Do you understand that?

A. Yes.

* * *

[17] Q. Does the Department regulate licensed abortion facilities?

[18] A. Yes, we do.

* * *

[20] MR. O'BRIEN: I want to mark as Exhibit 2 a document titled "State Defendants' Second Amended and Supplemental Responses and Objections to Plaintiffs' Second Set of Interrogatories" dated July 11, 2014.

(Exhibit 2 was marked.)

* * *

Q. (BY MR. O'BRIEN) Are you familiar with this document?

A. High level familiarity, yes.

[21] Q. So you've seen it before?

A. Yes.

Q. I'd like to refer you to—when would you have seen it?

A. In preparation for this.

Q. Would you have seen it any other time besides your preparation for the deposition today?

A. I don't—I don't think so.

Q. I'd like you to—to refer you to Page 6. Let me know once you're there.

A. Uh-huh.

Q. You'll see a heading "Specific Responses and Objections," and immediately below that is what is labeled as "Interrogatory No. 16."

A. Uh-huh.

Q. It reads, quote: For each ASC that is currently licensed by the State of Texas, identify: (a) its name; (b) its address; (c) its license number; and (d) whether it qualifies as an "existing licensed ASC" under 25 Texas Admin. Code Section 135.51(a)(1).

What do you understand Part D of that interrogatory to request?

A. Can I look at that code?

Q. Yes, if it will help you refresh your recollection.

* * *

[22] Q. Here is 51.

A. 51(a)(1).

(Witness reviews document.)

A. Okay. That means when these rules were adopted, everything previous to that, they—they're considered to be existing.

* * *

Q. [READING]: The provisions of this Section 135.51 adopted to be effective June 18th, 2009, 34 Texas Reg 3948.

Do you understand that to mean that the effective date for this regulation was June 18th, 2009?

A. Yes.

Q. Okay. So in light of that effective date, could you explain to me what you understand Section 135.51(a)(1) to say?

A. It basically says construction requirements that [23] were in place the day these rules—that anybody that was licensed before the day these rules became adopted met the standards of that—that day before, whatever those standards were at the time.

Q. Would it be okay with you if I referred to a facility that falls within this section as an existing licensed ASC?

A. Yes.

Q. Do you understand what I'm referring to when I say that?

A. Yes.

Q. So an existing licensed ASC is an ASC that obtained its license prior to June 18th, 2009. Correct?

A. Yes.

Q. And that—and an existing licensed ASC need only comply with the ASC requirements that were in effect when it obtained its license. Correct?

A. For construction.

Q. For construction.

A. Yes.

Q. That's correct?

A. Yes.

* * *

[24] Q. So I'm going to break that into two questions.

First, an ASC facility that is licensed after June 18th, 2009 must satisfy different standards for new construction than an existing ASC licensed facility. Correct?

A. Correct.

Q. And I'd also like to clarify, an existing licensed facility, one that obtains its license prior to June 18th, 2009.

If it engages in reconstruction, would it have to satisfy the new construction standards?

A. My understanding is they must meet the new construction standards.

* * *

[25] Q. (BY MR. O'BRIEN) Is it your understanding that as long as a facility operates continuously as an ASC, it remains subject to the existing standards?

A. That the—yes, that they were built under.

* * *

[28] I'm going to mark as Exhibit 3 a set of documents with Bates ranges DSHS_5296 to DSHS_5312.

(Exhibit 3 was marked.)

* * *

[29] Q. (BY MR. O'BRIEN) Ms. Perkins, are you familiar with what this document is?

A. It looks like it is a—it looks like it's information from one of my regulatory databases.

Q. Do you know what database that would be?

A. It would—I'm—I believe it's our regulatory automation system.

Q. Could you explain to me what the regulatory automation system is?

A. Yes. It is a database we use across my whole division where we put in information about licensee applications information and indicate whether a license is approved or not. It's also where we put

inspection data, enforcement data, et cetera. It's a comprehensive database.

[30] Q. Is that database searchable?

A Yes.

* * *

Q. Are you able to identify in this document which currently licensed ASC facilities qualify as existing licensed ASC facilities?

A. Not by just this document, no. I would have to see the search criteria.

* * *

[31] Q. I am marking as Exhibit 4 what I will represent to you and your counsel is a printout of the native file Bates stamped 7002, which is an Excel spreadsheet.

I'm going to provide two other clarifications. I want you to take a look at that first, though.

(Exhibit 4 was marked.)

Q. (BY MR. O'BRIEN) So prior to printing this document out, DSHS_7002, I'll represent to you that we sorted the data contained in here by the third to last column from the right which is labeled "Orig Date."

And we also highlighted all facilities, all entries with an orig date on or before June 18th, 2009. Are you familiar with this document?

A. (Nods.)

Q. Do you have any sense of where this document was produced from?

A. They could have been produced from the same database. I don't know that.

Q. When you say "the same database," what database are you referring to?

A. The regulatory automation system.

Can I clarify something? We do have two databases for health facilities. We have the Medicare database, which is where we have to do all our Medicare work, and then we have the regulatory automation system.

[32] So just looking at these like this, I'm not sure but I believe they're from the regulatory automation system but I'm not positive.

* * *

Q. (BY MR. O'BRIEN) Ms. Perkins, I understand you do not have an intimate familiarity with this document.

But to the extent you can, can you explain to me the meaning of the column labeled "File Nbr"? It's the first column on the left.

A. I will have to verify this, but what I believe is that we do have paper files of things and that that refers to a paper file number.

Q. Do you have an understanding of what "LIC#" signifies?

A. That's license number.

Q. And going over a little bit further in the chart, do you have an understanding of what "Expire Date" refers to?

A. That would be the date that the current license will expire.

Q. And do you have an understanding of what the "Status" column refers to?

[33] A. If the license is current right now.

* * *

Q. Do you have an understanding of what "Rank Date means?

A. Rank—if—I believe rank is not really—I believe "Rank Date" is—let me go to a different type of license, like a social work license. A social worker, a master of social work, et cetera, they'll have different ranks. That's what we call them in the database. And so what date did you attain that rank?

* * *

[34] Q. (BY MR. O'BRIEN) So if we can go one column over, there is a label "Alt Key."

Do you have an understanding of what that means?

A. I do not. I'm sorry.

Q. And then the final column, I'll represent to you that it's slightly cut off and that's a "Dba Name."

Is it your understanding that that would refer to the "doing business as" name?

A. Yes.

* * *

Well, before I do that, do you have an understanding of whether Whole Woman's Health San Antonio ASC is licensed as an existing facility?

[35] A. It says on this database that it's current and that it expires 8/31/2014. So as of this one—according to this, it is. I don't know what date this was produced.

Q. Do you know whether Whole Woman's Surgical Center is inspected under new construction standards?

A. Well, if it came in—it would—it—so construction standards only come into place on initial new and during reconstruction.

So when we do a regular inspection of a facility, unless there has been some kind of a complaint or concern, we don't look at the construction standards because whatever they were built under and licensed under is still in place for them.

* * *

[36] Q. (BY MR. O'BRIEN) We had discussed what the [37] columns were referencing to the extent you understood them.

Do you have a better understanding of what "Orig Date" means?

A. Yes.

Q. What does it mean?

A. The orig date is the date that the current—whoever the current licensee is, the current owner is, when they got the license.

Q. So is it correct, then, if the date in the "Orig Date" column predates June 18th, 2009, the ASC facility qualifies as an existing licensed ASC?

A. Yes.

Can I expand, please?

Q. Yes.

A. But the other way is not necessarily true. In other words, if the date is after, it does not necessarily mean that they don't qualify as an existing.

Q. Thank you.

A. Because if there was a change of ownership, it would go with that change of ownership. But that change of ownership, the building might still qualify as existing.

Q. We had previously discussed the entry on Page 5 for Whole Woman's Surgical Center just below the [38] highlighted portion.

Is that an example where the Orig Date post-dates June 18th, 2009 but the facility qualifies as an existing licensed ASC?

A. I believe so.

* * *

[39] [READING]: For each ASC that is currently licensed by the State of Texas, identify: (d), whether it qualifies as an "existing licensed ASC" under 25 Texas Administrative Code Section 135.51(a)(1)," which, I think, is what we've just been talking about.

In responding to the interrogatory, the Department identified a couple of documents which we've talked about this afternoon, and it seems like none of those documents fully answers the question, provides all [40] the information necessary to know which licensed ASCs qualify as existing ASCs and—you know, and then conversely, which ones are required to meet new construction standards.

Are there sources of information that the Department could draw on to provide that information in written form in a supplemental response to this interrogatory?

A. I would like to clarify that with my staff. I don't know.

* * *

[41] Q. And then I believe when we were off the record, we had a conversation about 25 Texas Administrative Code Section 135.51(b).

So do you have 135.51 in front of you?

A. Yes.

* * *

[43] Q. (BY MS. TOTI) So apart from those documents, do you have an understanding of how many instances there has been in the past five years in which the Department granted a conditional approval of minor deviations from the requirements of 25 Texas Administrative Code Section 135.52?

MR. BLACKLOCK: You can answer that.

A. I do not. They are not documented.

* * *

Q. Is the applicant for such a conditional approval required to submit any written request for that conditional approval?

A. No.

[44] Q. Is the applicant required to make a demonstration to the Department that—that the care, safety and welfare of patients will not be jeopardized?

A. My architects will look at the situation, and they'll make that judgment.

Q. So it's the Department's practice to grant the conditional approved described in Section 135.51(b) on a purely oral basis, without prior submission of any documentation by the applicant. Is that correct?

A. They'll probably look at plans or they'll show them the situation on-site at the construction site.

Q. But the Department doesn't retain any records that such a conditional approval has been granted?

A. Not necessarily, no.

Q. How would a future inspector know that—that such a conditional approval had been granted in the past?

A. The assumption would be made or else they would not have been—the project would never have been approved and completed.

* * *

[45] Q. (BY MS. TOTI) If there is no documentation of when these approvals are granted, wouldn't it be relatively easy for a facility to lie about having received such a conditional approval?

MR. BLACKLOCK: Objection; that calls for speculation, and it's not within her knowledge as the representative.

Q. (BY MS. TOTI) You can still answer.

MR. BLACKLOCK: You can. If you have anything to say.

A. The relationship between the architects out there and the architects, my architect, my engineers, is very collegial and I would get complaints if—I would have complaints if somebody changed their mind or something like that because construction was expensive. So I've not had any concerns raised to me about that.

Q. (BY MS. TOTI) Do you—does the Department have any knowledge of how often—does the Department have any knowledge of how often conditional approval of minor deviations of the kind described in Section 135.51(b) are granted?

A. I—I believe it's not infrequent.

Q. So it would be fair to say you think it happens [46] frequently?

A. Yes.

* * *

[51] Q. What's your understanding of the purpose of the ASC requirement?

A. To raise the standards of care for women getting abortions.

Q. What do you mean when you say "raise the standard of care"?

A. To—to assure that women having abortions are getting the same level of care that other patients having surgeries or the procedures are getting.

Q. Has the Department compiled any data to support the idea that such an increase in the standard of care, as you referred to it, would enhance patient safety and welfare?

A. Not that I'm aware of.

* * *

[52] Q. With respect to the admission privileges requirement, what types of admitting privileges are necessary for an abortion provider to be in compliance with the admission privileges requirement?

A. My understanding is that they just have to be able to admit a patient to the hospital.

* * *

Q. (BY MR. OBRIEN) How does the Department assess whether a physician is in compliance with the admission privileges requirement?

A. When my staff go on-site, whether by client or a routine inspection, they ask for documentation and they look at that documentation and then they follow back to the hospital to confirm.

Q. What would your—what do your inspectors need to identify in those documents to deem a physician in compliance with the admission privileges requirement?

A. I don't know that detail.

Q. If you can say what you inspectors need to see [53] to determine if a physician is in compliance

with the admission privileges requirement, how can a physician have fair notice of what must be done to comply with regulation?

A. Just give me

Do you have a number that you're referring to?

Q. I'm sorry?

MR. BLACKLOCK: Under 6.

MR. O'BRIEN: Yes, I'm sorry. That's correct.

Q. (BY MR. O'BRIEN) I didn't understand your question. I apologize.

MR. BLACKLOCK: Okay. We can probably provide you an answer from the Department with more detail on its position if you'll—after a break. We don't need a break now, we can provide it after the next break.

MR. O'BRIEN: I just want to clarify, though, are you going to provide documentation that explains, it or is she going to communicate with another staff member to get an answer?

MR. BLACKLOCK: I anticipate Ms. Perkins being able to give you more details on the nature of the admitting privileges requirement after a break.

MR. O'BRIEN: Okay.

Q. (BY MR. O'BRIEN) But as you sit here at this [54] moment, you don't know what specifically is

necessary to comply with the admission privileges requirement. Correct?

A. Correct.

MR. BLACKLOCK: And I'll note that since we have talked about getting that information after the break, it's not that that information is not known by the Department It's that it's simply not known at this moment by Ms. Perkins to the satisfaction of counsel.

Q. (BY MR. O'BRIEN) The Department has investigated at least one physician for noncompliance with the admission privileges requirement. Correct?

A. Yes.

Q. How many physicians has the Department investigated for noncompliance?

A. I think three.

Q. Do you know whether a specific standard for what type of privilege was necessary was identified as part of that investigation—those investigations?

A. I don't know.

* * *

Q. Yes. How does the process begin, and what [55] happens thereafter?

A. We receive a complaint. We assign it to the zone where most—many of my staff do multiple facility types. We assign it to that zone to go investigate.

And then they will go and do the investigation. And depending on the complaint—complaints are targeted, whereas an annual inspection is not. So they'll target, and they'll specifically ask questions about whatever that complaint was about.

* * *

Q. The admission privileges requirement includes what I refer to as the 30-miles requirement.

A. Uh-huh.

Q. What do you understand me to be saying when I refer to that?

A. My understanding is that they must have privileges in a hospital that have—that's within 30 miles of the abortion facility that provide surgical and/or OB services.

Q. How does the Department determine whether a hospital is within 30 miles?

A. I believe we use As the Crow Flies and Bing. We [56] just use, you know, those kind of map things to see if it meets that requirement.

Q. I just want to make sure I understand you. You use an online map. You referred to Bing.

Is that one you understand you specifically use?

A. I believe my staff use Bing, yes.

Q. And they determine 30 miles based on actual distance, or as you said As the Crow Flies, as opposed to driving distance or some other metric?

A. I believe so.

Q. Do you know whether that standard was applied in the past investigations you referenced earlier?

A. I believe so.

* * *

[59] MR. O'BRIEN: I'm going to mark as Exhibit 5 what is Bates range DSHS_2562 to 2567

I apologize this is not stapled.

(Exhibit 5 was marked.)

* * *

[66] (Exhibit 6 was marked.)

MR. O'BRIEN: Exhibit 6 is Bates ranges DSHS_1196 to 1197.

* * *

Q. (BY MR. O'BRIEN) Have you seen this e-mail before?

A. I don't recall this specific e-mail, but I believe I've seen the table before.

Q. I'm going to turn to the table in just a moment.

The e-mail is from Rachael Hendrickson.

She is a legislative liaison in the Department. Correct?

A. Yes.

Q. And it's an e-mail to an Alison Brock.

Do you who that is?

A. I do not.

Q. Based on the domain of the e-mail, do you have an understanding of whether Ms. Brock works for the State House?

A. Based on the e-mail, she would probably work for [67] a representative.

Q. Okay. In the first line of the e-mail it states: I have attached a table that covers the differences between ASCs and abortion facilities, for a high level overview.

And that table is on 1197.

Is that the table you were indicating you had a familiarity with?

A. It looks familiar, yes.

Q. I'd like to give you an opportunity to just review it for a moment, and then I'll ask you some questions. Just let me know when you are ready.

(Witness reviews document)

A. Okay.

Q. (BY MR. O'BRIEN) Does this table provide an accurate description of the differences between ASCs and abortion facilities at a high level for the specific characteristics identified: Procedures, Duration of Care, Licensure Fees, Licensing Survey Frequency and Life Safety Code Requirements?

A. Can I verify this is before the bill passed?

Q. That's correct. This e-mail is dated July 9th, 2013.

A. So before the bill passed, yes.

Q. Let me rephrase my question. This table provides [68] an accurate comparison of abortion facilities and ASCs at a high level prior to enactment of House Bill 2. Correct?

A. Yes.

Q. I'd like to direct you to the licensing survey frequency, Row 4, depending on how you count.

For abortion facilities, it states that: State licensing surveys are performed annually.

That's correct. Right?

A. Yes, by statute.

Q. In addition to those license—annual licensing surveys, there are also inspections based on complaints. Correct?

A. Correct.

Q. I'd like to look over at the next column regarding the ASC licensing survey frequency.

It states: That ASC surveys—pardon me—ASCs are surveyed at intervals not to exceed 6 years.

Is that correct?

A. It was correct at the time.

Q. Do you have an understanding if the intervals for surveys of ASCs has changed since July 9th, 2013?

A. My understanding is we do them every three years now.

Q. Do you have an understanding of whether that's a requirement or a matter of practice?

[69] A. I believe it is a requirement of Medicare.

Q. So taking the three-year period for surveys, that is still less frequent than the surveys of abortion facilities. Correct?

A. Yes.

* * *

[70] Q. Ms. Perkins, I'm going to mark as Exhibit 7

(Exhibit 7 was marked.)

* * *

[71] Can you first explain to me what this document is?

A. Yes. This document is a document my surveyors write up. It's called a Report of Contact. We use it across all my facility types that—it basically describes what was done in a complaint investigation, during a complaint investigation.

Q. So you have an understanding of the format of report of contacts generally. Correct?

A. Yes.

Q. And you indicated that you had a recollection of the particular investigation reflected in this report of contact. Correct?

A. Yes.

* * *

[75] Have inspections of abortion facilities increased since the passage of House Bill 2?

A. We're still doing inspections routinely annually. So we haven't changed that. And—that's not my sense that it has. We might have had a handful more, but it's not my sense it's been a major increase.

* * *

Q. (BY MR. O'BRIEN) Ms. Perkins, it's been represented to me that you recently had an opportunity to get some clarity regarding what admissions privileges were required to comply with the admission privileges requirement. Is that correct?

A. Yes.

[76] Q. Who did you speak with to get that information?

MR. BLACKLOCK: Object to the extent that gets into counsel communication.

THE WITNESS: So I don't answer?

MR. BLACKLOCK: You can tell him the document you consulted.

A. I have—there was a document I consulted.

Q. (BY MR. O'BRIEN) Could you describe this document to me, please?

A. It's a guidance document from my staff—on making determinations regarding admitting privileges.

Q. When you refer to your staff, are you referring to attorneys?

A. I'm referring to my surveyor staff.

Q. Do you have this document with you?

A. It's here, yes.

MR. O'BRIEN: Counsel, we're going to request that it be handed over if—

MR. BLACKLOCK: We'll object to that on the same—

MR. O'BRIEN: On what grounds?

MR. BLACKLOCK: —same procedure as other documents that have been talked about that have been to prepare you can ask for later.

* * *

[77] Q. (BY MR. OBRIEN) Could you describe the document you consulted during the break, Ms. Perkins?

A. It describes the—it has a column for the specific requirement and then it gives guidance to my staff on how they're to approach that requirement, and then gives a sample if they think there is a deficiency of that, how they would write that deficiency.

Q. Do you know when this document was produced—when this document was created?

A. Sometime after the bill passed.

Q. So it's been a significant while?

A. Yes.

Q. It was created prior to, just to be clear, April of this year?

A. I believe so.

[78] Q. Based on that document, what did you conclude a physician—what type of admitting privileges did you conclude a physician must hold to satisfy the admission privileges requirement?

A. There is no specific type of admitting privileges. As long as they can show they're on the medical staff of a hospital, that's all we look for.

Q. What do you mean when you say "on the medical staff of a hospital"?

A. Basically, when a hospital decides to provide—basically, the medical staff must agree, and each hospital does this differently, that a medical staff of a hospital has to agree—and I don't know the process the hospitals use—and that that doctor can be on their medical staff which would allow that doctor to admit the patient to the hospital.

Q. So each hospital could have a different standard. Is that correct?

A. They may have. They may, yes.

MR. BLACKLOCK: Objection; that's outside the scope.

Q. (BY MR. O'BRIEN) Has the document that you consulted to get an understanding of what requirements were necessary to satisfy the admission privileges requirement been made public before?

[79] A. I don't know.

Q. Would courtesy privileges at a hospital satisfy the admission privileges requirement?

A. I believe so.

Q. At a general level, aside from active admission privileges and courtesy privileges, are there other types of privileges commonly used or commonly referred to?

A. I've heard of like specific types of surgery, for example, you can do these but not these. You can admit to this kind of ward, not that kind of ward. But, again, each hospital, it's going to be dependent on the services the hospitals provide, and that really is in the purview of the hospital. So we just accept—they say he is, we'll accept it. He or she is.

Q. If an abortion provider has an admission privilege to perform any type of surgery, that would suffice to satisfy the requirement, then?

A. As I have already said, there is no limitations from our perspective.

Q. So there is no requirement that the admission privileges relate to abortion-related procedures that might occur at the hospital?

A. Not from our perspective, no.

* * *

[80] Q. Were the allegations substantiated?

A. I don't remember. I don't believe so.

Q. To the best of your knowledge?

A. To the best of my knowledge, I don't believe so.

MR. O'BRIEN: I'm going to mark as Exhibit 8 what is identified as DSHS_1732.

(Exhibit 8 was marked.)

* * *

[83] what is identified as DSHS_1372 through 1374. (Exhibit 9 was marked.)

* * *

[84] a couple of questions.

This is an e-mail from Allison Hughes at the Department dated July 2nd to you. Correct?

A. Uh-huh.

Q. You received this e-mail?

A. Yes.

Q. You read this e-mail?

A. Uh-huh.

Q. So you're familiar with this e-mail?

A. I get over 200 e-mails a day, so I actually don't remember this particular e-mail. But I remember the conversation. I remember the string.

Q. What was the conversation about generally?

A. It was about responding to the governor's office with a—the governor's office had a request—lieutenant governor. I'm sorry. Lieutenant governor.

* * *

[85] Q. She writes: If a physician in Texas is licensed to perform Level IV Office Based Anesthesia—and abide by the following strict standards and guidelines as set forth below from Chapter 192; it seems there wouldn't be many limitations on the specific procedures that a physician could perform in a clinic setting? NOTE: OBA registration is NOT required for hospitals or ASC's.

Did I read that accurately?

A. Uh-huh. Yes.

Q. What does OBA refer to?

A. Office-based anesthesia, I would assume.

Q. Do you have an understanding on whether what Ms. Hughes wrote there is accurate and correct?

A. She lists her source as the Texas Medical Board website. So I assume she pulled it right from that website.

Q. So you didn't have any reason to doubt the accuracy of what Ms. Hughes stated?

A. No.

* * *

[86] Q. The Department doesn't have oversight over facilities where office-based anesthesia occurs. Correct?

A. A physician may do abortions in his own clinic in Texas up to 50. If he does more than 50, then

he must—50 or more—I think it's above 50, he must be licensed as an abortion facility. So in that instance we would have some authority over a doctor's clinic. At that point they would have to become a licensed abortion facility. Otherwise we do not.

Q. So outside of the abortion context where more than 50 occurred, the Department would not have oversight over a facility performing office-based anesthesia?

A. If they were not licensed. If it's a physician's clinic, no, we do not.

Q. The Department tracks the number of licensed abortion facilities. Correct?

A. Yes.

Q. Why?

A. We track the number of licensed everything we have. We get requests for information on so many—[87]virtually all of the licenses. It's part of our numbers that we do every single year.

Q. How are the—how does the Department track the number of licensed abortion facilities?

A. Based on the current licenses that are—the licenses that are current in the database.

Q. And so the Department also tracks the closure of licensed abortion facilities, then. Right?

A. We have been doing that, yes.

Q. Is that something that was not—when did the Department begin tracking closures of licensed abortion facilities?

A. We were getting a number of inquiries after the abortion law passed.

Q. When you referred to the abortion law, you're referring to House Bill 2?

A. Correct.

Q. Did the Department begin tracking closure before enactment of House Bill 2?

A. Let me clarify. We tracked numbers of licensed facilities, closures. It just depends on what information people request from us. We track our licensing activity every year. These are regular statistics that we do all the time. But we were getting a number—on this particular issue we were getting a number of requests from [88] media, from legislators, from governor's office and so we wanted to be very clear and make sure. So, yes, we've been tracking that a little more closely than we do the others.

Q. So the Department has historically tracked closures even before enactment of House Bill 2. Correct?

A. Yes.

Q. And they just paid a little more attention to it given the attention that resulted from House Bill 2. Correct?

A. And we want to be accurate.

Q. So the Department has given more attention since the enactment of House Bill 2 to closures? I just want to make sure the record is clear on that.

A. Not because the bill passed, but because of the inquiries we are getting.

Q. Did the department anticipate that House Bill 2 would result in the closure of licensed abortion facilities?

A. That wasn't within our purview. That wasn't—we didn't—we are an administrative agency that implements laws that are passed by the legislature. We implemented the bill. That was not—we were not part of that.

Q. The Department regulates licensed abortion [89] facilities. Correct?

A. Correct.

Q. So the Department has an interest in knowing whether there will be fluctuations in the number of licensed abortion facilities because it will affect its regulations, its ability to—it would affect its oversight. Correct?

MR. BLACKLOCK: Objection; form.

Q. (BY MR. O'BRIEN) Let me rephrase before you answer that. I apologize.

The Department oversees licensed abortion facilities. Correct?

A. Yes.

Q. So the department has an interest in understanding how many licensed abortion facilities currently exist. Correct?

A. The Department has an interest in its total workload. Its total workload.

Q. And the department would want to anticipate whether its workload is going to increase or decrease in the future. Correct?

A. Yes.

Q. So the Department would have an interest in understanding whether certain laws would have an impact on the number of licensed abortion facilities, whether that [90] number were going up or down. Correct?

A. Overall the number of healthcare facilities in the State of Texas is climbing precipitously, more than 100 percent in the last decade, doubled the number. So with the numbers of abortion facilities, it was not going to make that big of a difference.

Q. So the Department didn't have any interest in considering whether abortion—licensed abortion facilities would increase or decrease as a result of Bill 2?

A. No. We're looking at the global numbers, because my surveyors do virtually all of the healthcare facilities, and so the global numbers that I'm going to have to deal with is what we're more likely to look at.

Q. The Department doesn't pay any particularize attention to licensed abortion providers?

A. We follow the requirements of the statute, we look at the—yes, we pay attention to them based on complaints, investigations, et cetera. But the volume is not—as compared to the other healthcare facilities, it is small.

Q. In advance of passage of House Bill 2, did the Department have an understanding of how many existing abortion facilities would meet the ASC standards that will go into effect in September?

[91] A. We did not.

Q. Does the ASC have a current understanding of how many licensed abortion facilities will meet the ASC standards once it goes—once House Bill 2's ASC requirement goes into effect?

A. They do not.

MR. BLACKLOCK: Objection; form.

You need to rephrase that.

Q. (BY MR. O'BRIEN) You understood the question?

A. We do not.

MR. BLACKLOCK: The question was stated incorrectly. You should restate it if you want to.

Q. (BY MR. O'BRIEN) Ms. Perkins, I'm going to refer you to what I'm going to mark as Exhibit 10 and it is labeled DSHS_773 through 774.

* * *

A. So let me just clarify the answer to my last question. My understanding—you asked me if I know how many of the—excuse me—the current abortion facilities meet ASC standards. And I—as of when—at 9/1 and I do not—that prior answer I do not know. Is [92] that what you asked me?

Q. (BY MR. O'BRIEN) When you say as of 9/1 referring to 9/1/2014, when the ASC requirements effect?

A. Right.

Q. Correct.

A. That's what you asked me.

Q. Yes. Does the Department have that information?

A. Does the Department have—no, not to my knowledge.

(Counsel and witness confer.)

A. So let me clarify one other thing. Ambulatory surgery centers that do abortions are not licensed abortion facilities. Correct? You understand that?

Q. (BY MR. O'BRIEN) What you said was—correct me if I'm misunderstanding, you said ASC facilities that perform abortions are not licensed as abortion providers. Correct?

A. Correct.

And any ambulatory surgery center right now that that does abortions will obviously meet the ambulatory surgery center requirements on 9/1.

I want to make sure we're talking the same language here.

Q. So what I'd like to ask you about is licensed [93] abortion facilities that are not ASC centers.

A. Okay.

Q. And it's my understanding from what you said that all licensed abortion facilities currently are not ASC because an ASC does not—that performs abortions does not have to obtain—become a licensed abortion provider. Correct?

A. Correct.

Q. So does the Department have information or data regarding whether the existing—regarding how many of the existing licensed abortion facilities could, as of today, meet the ASC requirements?

A. I do not believe so.

Q. Okay. I'm going to provide you with Exhibit 10, which I believe I indicated was DSHS_773 through 774.

(Exhibit 10 was marked.)

Q. (BY MR. O'BRIEN) This is an e-mail chain with the top e-mail from Pamela Adams of the Department to Carrie Williams with the subject line: Abortion Clinics—Closures."

And it's dated February 8th, 2014. Correct?

A. Yes.

Q. And if you look down to the first e-mail in the chain, which is at the bottom of the page on 773, it's an e-mail from Carrie Williams on February 18th to Pamela [94] Adams. Correct?

A. Yes.

* * *

Q. So going back up to the first e-mail—the top e-mail in the chain from Ms. Adams, what do you understand—there is a chart in the middle. I'll call that a chart of months with dashes and then a number following it.

What do you understand that chart to reflect?

A. Okay. So each month that shows and was probably—yeah, it's the 1st of the month—how many

abortion facilities were licensed on the 1st of the month.

Q. So each of those entries shows how many abortion [95] facilities were licensed at the beginning of the month identified for that particular line. Correct?

A. Correct.

Q. Do you have any reason to believe Ms. Adams' information was incorrect?

A. We had to—I don't—I think she believed it was correct when she provided it, but I also know that we have had to be sure that all of my staff are speaking the same language. I have 930 FTEs that work for me. And what did we mean by closure.

So I at some point—and I don't know what that point was, we became much more strict about how we provided this information and what we meant by a closure and we have had—basically we need the license back before we count it as a closure.

So she probably gave information she believed was correct at that time.

Q. You don't have any knowledge that Ms. Adams was not relying on submission of licenses to compute closure though. Correct?

A. I don't know about Ms. Adams. I do know that there was some confusion among my staff, and so we clarified our process.

* * *

[96] I'm going to mark as Exhibit 11 a document identified as DSHS_792 through 796.

(Exhibit 11 was marked.)

Q. (BY MR. O'BRIEN) I'll walk you through this to orient you a bit.

(Witness reviews document.)

* * *

MR. BLACKLOCK: I'm going to object to—objection. That covers all these e-mails on which Ms. Perkins is not included, that she doesn't have a foundation for knowing about them. And she's being asked to speculate about what's in them and can't speak for the [97] people who actually wrote them and received them and certainly cannot speak on behalf of the Department as what they mean because she wasn't involved in the creation of them.

* * *

[98] Q. (BY MR. O'BRIEN) Ms. Perkins, would you take a moment to read through this e-mail, please.

* * *

MR. BLACKLOCK: My objection is on the record. I have a standing objection that I announced early on to questions that get outside the scope of the notice and what can be—could reasonably have been investigated based on the notice. It's my position

these questions are outside of that scope and, therefore, she's not testifying on behalf of the Department. I will allow [99] her to testify in her personal capacity.

* * *

Q. (BY MR. O'BRIEN) Ms. Perkins, have you had an opportunity to review this e-mail?

A. Yes.

Q. Do you have a sense of what this e-mail is about?

A. Yes.

Q. Could you explain that sense to me, please?

A. I can't speak to individual names, et cetera, but what it appears is that my staff person, Gina Smith, received some kind of communication from this Dr. Gonzalez-Vera regarding how to close the facility, what is the requirement. These are very common communications that my staff get all the time. "I'm going to close the hospital. I'm going to close an ASC. How do I do it?"

It looks like she responded with the wording right from the rule, it looks like, to me. Yes, it's from the rule, and then she forwarded it up her chain to her manager.

Q. In the first facility that is being referred to as closing is the Aalto Women's Center, License No. 00739. Is that correct? If you look at Page 793, that may orient you.

[100] A. I'm not seeing a license number, but it is Aalto.

Q. I'll refer you the top of Page 793 where it says: "On February 19th, 2014 at 9:32."

A. There it is. I'm sorry, I couldn't see it.

Q. So the facility that was initially being discussed as closing was the Aalto Women's Center, License No. 7319. Correct? Is that your understanding?

A. That's what it looks like.

Q. In that e-mail that I was just referring to you, it also states: Reproductive Services of Harlingen also called yesterday and said they are closing.

Is it your understanding that Reproductive Services of Harlingen has closed?

A. I believe so, but not at this point, I don't believe. But I believe they have closed but I'd have to verify that for you.

Q. To the best of your knowledge currently, you believe that the Reproductive Services of Harlingen has closed?

A. I know there was a time they didn't want to send their license back. They were going to continue to provide—they just didn't want to send the license back. So I don't know the actual status of them today.

Q. So at a minimum, you understand that the Reproductive Services of Harlingen intended to close. Is [101] that correct?

A. It says they said they are closing.

Q. What steps would need to be taken for the Reproductive Services Center of Harlingen to confirm status as closed?

A. Send the license back.

* * *

Q. To the best of the Department's knowledge, Reproductive Services of Harlingen is no longer providing abortion services. Correct?

A. I don't believe.

Q. I just want to make sure that I'm understanding you correctly.

To the best of the Department's knowledge, Reproductive Services of Harlingen does not provide abortion services any longer. Is that correct?

A. I don't believe so.

Q. You don't believe they provide abortion services any longer. Correct?

[102] A. I don't believe they do.

Q. You don't believe they provide abortion services?

A. I don't think they are currently providing abortion services.

* * *

[104] Q. Ms. Perkins, are you familiar with the Coastal Birth Control Center of Corpus Christi?

A. Not personally, but I know it was one of the facilities that was licensed.

Q. And the department understands that that facility has closed. Correct?

A. Yes.

MR. O'BRIEN: Ms. Perkins, I'm going to mark as Exhibit 12 what is identified as DSHS_1082 to 1083.

(Exhibit 12 was marked.)

Q. (BY MR. O'BRIEN) This is a series of e-mails, and at the top of the chain is an e-mail from Ellen Cooper to you.

A. Yes.

Q. And it's dated April 22nd, 2014. Correct?

A. Yes.

Q. You received this e-mail?

A. Yes.

Q. You read this e-mail?

A. Yes.

[105] Q. Do you have a recollection of the general topic about—that this e-mail was about?

A. Yes. The—yes.

Q. And what is your recollection?

A. There was an idea of being able to have a mobile ambulatory surgical center to go around the state.

Q. And that idea was Ms. Hagstrom-Miller's. Correct?

A. Uh-huh. Yes.

* * *

Q. So Ms. Hagstrom-Miller is writing to you to see if the Department would approve a mobile ASC unit. Correct?

A. Yes.

[106] Q. And I want to go—you see a series of e-mails in this inquiry from Ms. Hagstrom-Miller gets forwarded a couple of times. Correct?

A. Uh-huh.

Q. If you look on Page 1082 the second e-mail from the top is from Renee Clark?

A. Clack.

Q. My apologies. Renee Clack to Jane Guerrero. Correct?

A. Uh-huh.

Q. But you're copied on this e-mail. Correct?

A. Yes.

Q. And you received this e-mail?

A. Yes.

Q. And you read this e-mail?

A. Yes, sir.

Q. Ms. Clack states: We haven't approved any mobile ASCs to my knowledge and sure won't begin now

What did you understand Ms. Clack to mean?

A. We had actually had somebody come and park what they wanted us to license a mobile ASC a couple of years before this, where they could go around to rural areas and do surgery. And when my staff got—they didn't even ask us. They just parked it on our parking lot, and so we went and we looked at it and my staff found blood, they [107] found—it was obvious that sterile conditions couldn't be contained in a mobile unit like that, and so we told that person at that time no. And he was pretty upset about it. And so what Ms. Clack is referring—that's what she's referring to.

We haven't approved a mobile ASC. And there were a lot of concerns on the part of my staff that it would not be a good model, that it could not be good for patient health and safety.

Q. If you go down one e-mail, there is an e-mail dated April 21st from Jane Guerrero. And she states:

I don't have any input except it sounds reminiscent of the mobile ERSD trailer we looked at 10+ years ago.

Is that what you were just referring to?

A. Yes, but I'm pretty sure it wasn't ERSD. I'm pretty sure it was an ambulatory surgery center. But either way it was a mobile unit that would be moved around in a truck and then parked and set up, and then patients would either have surgery or—or dialysis. And it was obvious it couldn't be kept clean.

Q. And when you say "it was obvious it couldn't be kept clean," you're referring to that specific trailer. Correct?

A. That trailer that we saw.

Q. That trailer that was looked at ten-plus years [108] ago. Correct?

A. That—it was quite a while ago.

Q. And Ms. Clack says: We haven't approved any mobile ASCs to my knowledge and sure won't begin now

Why wouldn't the Department look at mobile ASCs again after ten-plus years?

A. Well, it's unlikely that they would be able to maintain sterile conditions.

Q. Your conclusion that it is unlikely to maintain sterile conditions is based off your experience

with the trailer referred to in Ms. Guerrero's April 21st e-mail. Correct?

A. Yes.

MR. O'BRIEN: I'm going to mark as—

A. May I say one other thing?

Q. (BY MR. O'BRIEN) Sure.

A. They probably cannot meet life safety code requirements and construction standards. That's says Gerard would have a lot to say.

Q. I'm sorry, who would have a lot to say?

A. Right here. "Gerard will have a lot to say," in Guerrero's e-mail. Gerard is my architect.

Q. But you didn't do any particular investigation, to your knowledge, about this ASC—mobile ASC proposal from Ms. Hagstrom-Miller. Correct?

[109] A. No. It looks like my staff called on my behalf.

MR. O'BRIEN: I'd like to mark as Exhibit 13 a document DSHS_2390 to 2391.

(Exhibit 13 was marked.)

Q. (BY MR. O'BRIEN) Ms. Perkins, the top e-mail in this chain is an e-mail from you to Ms. Hagstrom-Miller. Correct?

A. Yes.

Q. And in it you wrote: My apologies for not responding sooner. I wanted to confirm that I have received your e-mail and have forwarded it to our Office of General Counsel for consideration.

And your e-mail—the e-mail you are referencing is Ms. Perkins's [sic] request that you look into her proposal for a mobile ASC. Correct?

A. Yes.

Q. So you did respond to Ms. Hagstrom-Miller ultimately, if I understand you.

A. Yeah.

Q. Is that correct?

A. Yes.

Q. But what you told her was that you forwarded her inquiry to the Office of General Counsel for consideration?

A. Yes.

* * *

[110] Q. (BY MR. O'BRIEN) Did you ever follow up with Ms. Hagstrom-Miller regarding the mobile ASC after this e-mail dated April 29th?

A. No.

* * *

Q. (BY MR. O'BRIEN) Ms. Perkins, I'm going to mark as Exhibit 14 a document entitled "Plaintiffs'

Fifth Request For the Production of Document Demands."

(Exhibit 14 was marked.)

Q. (BY MR. O'BRIEN) I'm sorry. It is titled "Plaintiffs' Fifth Request For the Production of Documents to Defendants," and it is dated July 2nd, 2014.

* * *

[112] Q. (BY MR. O'BRIEN) Do you recall engaging in conversations with your staff about how to appropriately respond to this document request?

A. My guidance to my staff on all of these requests that we have received has been to search broadly, default to provide everything that—that you think potentially might be responsive, go to paper, go to e-mail. That has been my direction to my staff on all the requests.

* * *

[113] Q. I'd like to focus your attention to No. 46. That requests all documents concerning the claim in Paragraph No. 7 of the rebuttal report of Deborah Kitz, Ph.D. that, quote: [a]s of May 16th, 2014, there were 58, one OR ASCs licensed in Texas.

Did I read that correctly?

A. One OR ASCs, yes.

* * *

Q. Are you aware of whether the Department provided any information to Deborah Kitz concerning the number of licensed ASCs in Texas that only have a single operating room?

A. I don't know.

Q. Do you know whether there was anyone in the Department that served as a point person for gathering information for the defendants' expert witnesses in this case?

A. No, I don't know.

* * *

[114] Q. So you don't know—you don't know whether this information had been provided to Ms. Kitz or provided to Counsel to provide to Ms. Kitz?

A. I don't know.

Q. Okay. Concerning Request No. 47, it asks for: All documents concerning Trinity Surgery Center in San Antonio, referenced in paragraph no. 28 of the Rebuttal Report of Deborah Kitz, Ph.D., including all documents concerning the facility that have been provided to or reviewed by the Architectural Review Unit at the Texas Department of State Health Services; all communications by or with the Architectural Review Unit in the Texas Department of State Health Services concerning the facility; all documents concerning the design, layout, or floor plan to the facility; all documents concerning whether the facility was licensed as an "existing" ambulatory surgical center

pursuant to 25 Texas Administrative Code Section 135.51 or instead as a "new" ambulatory surgical center pursuant to 25 Texas Administrative Code Section 135.52; and all documents concerning any "conditional approval of minor deviations from the requirement of Section 135.52," i.e., waiver, granted to the facility pursuant to 25 Texas [115] Administrative Code 135.51(b).

Do you know whether any effort was made by the architectural review unit to gather the documents identified in this request?

A. I don't know.

* * *

[116] Q. Okay. Request No. 40—refer to Exhibit No. 14, which are Plaintiffs' Fifth Requests For the Production of 3 Documents to Defendants, Request No. 48 asks, again, for: Documents referred to in the rebuttal report of Deborah Kitz that are identified as Texas Department of State Health Services miscellaneous matters, including, without limitation, ambulatory surgical center (ASC) listings and compilation of information reporting annually by ASCs.

And then some other things.

Do you know whether—strike that.

Do you know who in the department compiled this miscellaneous information that Dr. Kitz is referring to?

A. I do not.

Q. In this same exhibit, Request No. 49 refers to a document called "Special Tabulation of Texas Abortion Clinic Licenses by Year Opened and Closed" 2014.

And it's attributed to the Texas Department of State Health Services Center For Health Statistics and it's referred to in Paragraph 14 of the rebuttal report of Dr. Peter Uhlenberg.

Do you have information concerning this special tabulation of Texas abortion clinic licenses?

A. I do not.

[117] Q. Do you know who might have compiled that?

A. It says Center For Health Statistics.

Q. Do you know who at the Center For Health Statistics might have put this together?

A. I do not.

* * *

(Exhibit 15 was marked.)

Q. (BY MS. TOTI) I'll give you a minute to look through it.

(Witness reviews document.)

* * *

Q. (BY MS. TOTI) Ms. Perkins, are you familiar with this document?

A. I'm familiar with reports of contact. But about this one particular, I don't know that I've read this fully and I don't—I don't know.

[118] Q. What is a report of contact?

A. Report of contact is a document put together by my staff that's not—it's used in multiple facility types and they basically outline the facility, what the complaint was, what the purposes of the visit. They have a format that they follow for—for reports of contact.

Q. Would it be fair to say that a report of contact is the Department's summary of a complaint investigation?

A. It's—yes.

* * *

[123] Q. Ms. Perkins, the Department doesn't require physicians who treat complications from self-induced abortions to file reports, does it?

A. I do not believe so.

Q. The Department doesn't collect data on the self-induction of abortions. Correct?

A. I don't believe so.

* * *

MR. O'BRIEN: I'm going to mark as Exhibit 16 a document with Bates stamp DSHS_3072 to 3074.

[124] (Exhibit 16 was marked.)

* * *

Q. I'd like to give you an opportunity to particularly familiarize yourself with the first e-mail in the chain, the top one on 3072. But you're welcome to take a look at the whole document.

(Witness reviews document.)

* * *

Q. (BY MR. O'BRIEN) Ms. Perkins, the top e-mail in the chain is from Ms. Ellen Cooper of the Department to a Tonya Osborn of the Department. Correct?

A. Yes.

Q. And it's dated February 27th, 2014. Is that right?

A. Yes.

Q. And the subject line is "abortion performed by patient" Correct?

[125] A. Yes.

* * *

The body of the e-mail states in the first line of the second paragraph: Patient self-induced abortions are not reportable.

Do you understand Ms. Cooper to be telling Ms. Osborn that self-induced abortions are not reportable under department standards?

A. That's what Ms. Cooper is saying.

Q. And that's consistent with the understanding that you reflected earlier. Correct?

A. Yes.

* * *

Q. In that e-mail Ms. Osborn writes: Ellen, I received an Induced Abortion Report from a hospital reporting "elective induced AB performed at home by patient."

Do you understand that to refer to a patient self-inducing an abortion?

A. That's what it looks to be saying, yes.

Q. And Ellen states that—Ms. Osborn states that [126] she received an induced abortion report form from a hospital reporting such a self-induced abortion. Correct?

A. Correct.

Q. So the Department is at least aware that self-induced abortions occur?

A. The Department obviously received this. Yes.

Q. Ms. Osborn goes on to state: I haven't contacted the hospital to clarify, but it looks like the patient presented to the hospital with complications from attempting her own abortion.

Is it correct, then, the Department is receiving information from a hospital about complications from a self-induced abortion?

A. In this instance, it appears so, yes.

Q. Do you have—so the Department is aware that self-induced abortions occur. Correct?

A. The Department is aware that one may have occurred here.

Q. Okay.

A. But this was what was reported by a hospital. I don't know that it was ever verified.

* * *

[127] I'm going to mark as Exhibit 17 a document identified as DSHS_7499 through 7506.

(Exhibit 17 was marked.)

Q. (BY MR. O'BRIEN) And I just want to orient you to the top e-mail on the e-mail on Page 7499.

It's an e-mail from John Seago. Is that correct?

A. Yes.

Q. Do you know who John Seago is?

A. No.

Q. Are you familiar with Texas Right to Life?

A. I've heard of the organization, yes.

Q. What's your understanding of that organization?

A. I haven't really interacted with them. I've just heard of them.

Q. Do you understand them to be a pro-life interest group?

A. Yes.

Q. The e-mail is sent on December 26th, 2013 to DSHS complaints.

Who receives e-mails to that address?

A. It goes into an e-mail box, and then I have staff that review that box.

[128] Q. And e-mails sent to that inbox are complaints being filed with the Department. Correct?

A. Not necessarily. People use the e-mail boxes. It could be a number of different things that could end in that e-mail box, but that's the purpose of the box, yes.

Q. So the purpose of the box is for people who want to file a complaint to have a place—to have an e-mail address to send it to. Correct?

A. Yes.

* * *

[130] MR. O'BRIEN: I'm going to mark as Exhibit 18 a document identified as DSHS_80486.

(Exhibit 18 was marked.)

* * *

[131] Q. It's the last page. This is an e-mail from Ms. Osborn to a Ms. Baskin at the Department, and the subject line is "abortion performed by patient"

And the e-mail reads: Lynda, I wanted clarification. I received an Induced Abortion Report from—Form from a hospital which reported "elective induced AB performed at home by patient."

And, again, elective induced AB performed at home by patient you understand to mean a self-induced abortion. Correct?

A. Yes.

Q. It goes on to state in the second line from the bottom: Does the State collect information on abortions by patient?

And if you go up an e-mail to 805, Ms. Baskin responds to Ms. Osborn on February 21st and states in the second line—I'll start in the first line: The law that we follow requires abortion providers—

That's underlined.

—to report abortions to the state. Since [132] abortion providers have nothing to do with this abortion, I believe that we do not need this report.

Again, this is consistent with your understanding that the Department does not collect data regarding to self-induced abortions. Correct?

A. Correct.

Q. That includes complications stemming from self-induced abortions. Correct?

A. Correct.

* * *

[133] MR. BLACKLOCK: Before we go off the record, I want to reiterate the standing objection that I made at the opening in which opposing counsel agreed to allow to—questions that have been asked outside the scope of the notice for the sake of time and everyone's sanity, we didn't bother with that at every single point. But to the point the questions are raised later about the capacity many in Ms. Perkins was answering some of these questions, that objection was made as a standing objection and can be raised later.

MS. TOTI: Understood.

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

Whole Woman's Health, et al., Plaintiffs, v. **David Lakey, M.D.**, Commissioner of the Texas Department of State Health Services, et al., Defendants.	Civil Action No. 1:14-cv-284-LY

NOTICE OF APPEAL

(Filed Aug. 29, 2014)

Defendants David Lakey, M.D., in his official capacity as Commissioner of the Texas Department of State Health Services, and Mari Robinson, in her official capacity as Executive Director of the Texas Medical Board, appeal to the United States Court of Appeals for the Fifth Circuit from the final judgment entered on August 29, 2014 (doc. 199).

Respectfully submitted.

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Attorney General of Texas

DANIEL T. HODGE
First Assistant Attorney General

JAMES D. BLACKLOCK
Deputy Attorney General
for Legal Counsel

/s/ Jonathan F. Mitchell
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COUNSEL FOR DEFENDANTS
DAVID LAKEY, M.D., AND
MARI ROBINSON

Dated: August 29, 2014

[Certificate Of Service Omitted]

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF TEXAS AUSTIN DIVISION

WHOLE WOMAN'S HEALTH; AUSTIN WOMEN'S HEALTH CENTER; KILLEEN WOMEN'S HEALTH CENTER; NOVA HEALTH SYSTEMS d/b/a REPRODUCTIVE SERVICES; SHERWOOD C. LYNN, JR., M.D.; PAMELA J. RICHTER, D.O.; and LENDOL L. DAVIS, M.D., on behalf of themselves and their patients, Plaintiffs, v. DAVID LAKEY, M.D.. Commissioner of the Texas Department of State Health Services; and MARI ROBINSON, Executive Director of the Texas Medical Board, in their official capacities, Defendants.	CIVIL ACTION CASE NO. 1:14-CV-284-LY

PLAINTIFFS' NOTICE OF CROSS-APPEAL

(Filed Sep. 10, 2014)

Pursuant to Rule 4(a)(3) of the Federal Rules of Appellate Procedure, the Plaintiffs hereby cross-appeal to the United States Court of Appeals for the

Fifth Circuit from the final judgment entered on August 29, 2014 (Dkt. No. 199). In particular, Plaintiffs seek to raise the following issues on appeal:

(1) Whether the district court erred in declining to invalidate the "ambulatory surgery center requirement" (set forth in Tex. Health & Safety Code Ann. § 245.010(a) and 25 Tex. Admin. Code § 139.40) independently in all of its applications; and

(2) Whether the district court erred in dismissing Plaintiffs' equal protection and unlawful delegation claims in its Order dated August 1, 2014 (Dkt. No. 148).

Dated: September 10, 2014

/S/ Stephanie Toti

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[Certificate Of Service Omitted]

United States Court of Appeals
FIFTH CIRCUIT
OFFICE OF THE CLERK

LYLE W. CAYCE
CLERK

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June 11, 2015

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No. 14-50928 Whole Woman's Health, et al
v. David Lakey, et al
USDC No. 1:14-CV-284

Dear Counsel:

The Court has directed the following with reference to the Appellees Motion to Stay the Mandate filed on June 10:

1. By **June 12, 2015,** the Plaintiffs-Appellees' counsel shall file a **letter** stating, as officers of the court, the following information:

a. What clinics in the state of Texas that were currently open and regularly providing abortion services as of June 9, 2015, would be "forced to close" (as asserted in the Motion to Stay) if Appellees' Motion to Stay the Mandate were denied?

b. Other than the clinics stipulated by the parties to be ASC-compliant are any other ASC-compliant clinics in Texas that provide abortion services which are currently open or scheduled to open in the future?

With respect to a and b above, please provide the name and location of the clinics you reference.

2. The Defendants-Appellants shall file a **response** to the Appellees' Motion to Stay the Mandate, as well as a **letter** responding to the above-ordered letter, no later than **June 15, 2015**.

Sincerely,

LYLE W CAYCE, Clerk

By: /s/ Mary Frances Yeager
Mary Frances Yeager, Deputy Clerk
504-310-7686

cc: Mr. James Davis Blacklock
Mr. Scott A. Keller
Ms. Beth Ellen Klusmann
Mr. Michael P. Murphy
Mr. Andrew S. Oldham

United States Court of Appeals
for the Fifth Circuit

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June 12, 2015

VIA ECF

Lyle W. Cayce, Clerk of Court
U.S. Court of Appeals for the Fifth Circuit
600 S. Maestri Place
New Orleans, LA 70130

Re: ***Whole Woman's Health, et al. v. Kirk Cole, M.D., et al.*****, No. 14-50928**

Dear Mr. Cayce:

As counsel for Appellees and an officer of the Court, I provide the following information in response to the Court's directive of June 11, 2015.

Prior to the enactment of the challenged requirements, Texas had 41 licensed facilities providing abortion services on a regular basis. By the time of trial, that number had fallen to 20. Today, it stands at 19. The initial factor driving the reduction in abortion facilities was the admitting-privileges requirement. Shortly after its enactment, 8 facilities that could not

comply ceased providing abortion services. Eleven more ceased providing abortion services after a pre-enforcement challenge to the admitting-privileges requirement was unsuccessful. Since then, several more facilities have had to cease providing abortion services permanently or during long intervals as hospitals have declined to renew their doctors' admitting privileges.

Of the 19 facilities currently providing abortion services in Texas on a regular basis, I am aware of 10 that would have to cease providing abortion services permanently and an eleventh that would have to cease providing abortion services for an indefinite period of time—likely months—if Appellees' motion for a stay were denied. In addition, a twelfth facility that is poised to reopen would be prevented from doing so.

Ten Additional Abortion Facilities Would be Forced to Close Permanently

If Appellees' motion for a stay were denied, the following 10 clinics would have to cease providing abortion services permanently because they are not able to meet the ASC requirement:

	Facility Name	Facility Location
1	Austin Women's Health Center	Austin
2	Hilltop Women's Reproductive Clinic	El Paso
3	Houston Women's Clinic	Houston
4	Planned Parenthood—Babcock Road	San Antonio

5	Routh Street Women's Clinic	Dallas
6	Suburban Women's Clinic NW	Houston
7	Suburban Women's Clinic SW	Houston
8	Whole Woman's Health of Forth Worth	Fort Worth
9	Whole Woman's Health of San Antonio	San Antonio
10	Women's Center of Houston	Houston

The McAllen Clinic Would be Forced to Close For an Indefinite Period of Time—Likely Months

The eleventh facility is Whole Woman's Health of McAllen. If Appellees' motion for a stay is denied, the McAllen clinic would have to comply with all aspects of the ASC requirement except 22 Tex. Admin. Code §§ 135.51-135.56 and § 135.41. It would not be possible for the facility to come into compliance with these requirements by July 1, 2015. Among other things, Whole Woman's Health would have to hire and train new nursing staff members; modify many of its existing policies, procedures, and forms; and train its existing staff on those new policies, procedures, and forms. Consequently, it would have to close for an indefinite period of time—likely months—as it attempted to achieve compliance. Further, pursuant to the Court's decision, only one of its physicians could continue to offer abortion services there, and only to women residing in four counties. As a result, if and when the McAllen clinic were able to reopen, it would only be able to provide services on a limited basis—not to the full extent of patient demand.

The El Paso Clinic Would be Prevented From Reopening

The twelfth facility is Reproductive Services of El Paso. As the parties explained in their merits briefing, this facility ceased providing abortion services on April 11, 2014, as a result of the admitting-privileges requirement, and surrendered its license on May 29, 2014, when its annual assessment was due, because the nonprofit organization that operates it could not afford to pay the required fee while not providing services. Following the Supreme Court's order of October 14, 2014, which restored the district court's injunctions with respect to the El Paso clinic, Reproductive Services began taking the steps required for it to resume providing abortion services in El Paso, which included signing a new lease and hiring and training new staff members to replace those who had been laid off when the facility closed. On February 9, 2015, it filed an application for a new abortion facility license with the Texas Department of State Health Services ("DSHS"), together with the $5,000 application fee. This application remains pending. Because the El Paso clinic cannot meet the ASC requirement, its licensure application will be denied unless the ASC requirement is enjoined. As a result, if Appellees' motion for a stay is granted, the El Paso clinic will be able to reopen as soon as DSHS finishes processing its application, but if the motion is denied, the El Paso clinic will be forced to remain closed.

Currently, There Are Eight ASC-Compliant Abortion Facilities in Texas

At trial, the parties stipulated that six abortion facilities—each a licensed ASC—would be able to satisfy the ASC requirement as of September 1, 2014. To the best of my knowledge, each of those six facilities is currently providing abortion services on a regular basis. In addition, the parties stipulated that Planned Parenthood had obtained an ASC license for a seventh abortion facility, located in Dallas. That facility is currently open and providing abortions on a regular basis. The parties further stipulated that Planned Parenthood had plans to open an eighth ASC-compliant abortion facility, located in San Antonio, and had announced its intention to begin offering abortion services there in September 2014. To date, Planned Parenthood has not obtained an ASC license for that facility and no abortions have been provided there.

I am aware of one other abortion facility that currently meets the ASC requirement: Alamo Women's Reproductive Services, a licensed ASC that opened in San Antonio earlier this month. The trial record includes testimony concerning the plans for this facility, *see* Designation of Deposition Testimony of Marilyn Eldridge at 105:20-107:16, but the parties did not include reference to it in any of their stipulations because, at the time, information concerning the facility was too speculative.

Conclusion

In sum, of the 19 facilities currently providing abortion services in Texas on a regular basis, only eight would be able to continue providing those services as of July 1, 2015, if Appellees' motion for a stay is denied. The others would be forced to cease providing abortions—the McAllen clinic for an indefinite period of time and the remaining facilities permanently. Further, denial of Appellees' motion would prevent the El Paso clinic from reopening.

Finally, given the time-sensitive nature of Appellees' motion and the likelihood that the losing party will seek relief from the Supreme Court, Appellees respectfully request that the Court rule on their motion on or before June 19, 2015. Appellees believe that a ruling by this date would permit the Supreme Court to consider the losing party's request for relief by July 1, 2015, or shortly thereafter.

Yours truly,

/s/ Stephanie Toti

Stephanie Toti
Counsel for Appellees

cc: All Counsel of Record

[SEAL]

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June 15, 2015

VIA ECF

Mr. Lyle W. Cayce, Clerk
U.S. Court of Appeals for the Fifth Circuit
600 S. Maestri Pl.
New Orleans, LA 70130

Re: *Whole Woman's Health v. Cole*, No. 14-50928

Dear Mr. Cayce:

Defendants submit this letter pursuant to the Court's June 11 order. Plaintiffs' June 12 letter confirms that every area that had an operational abortion facility on June 9, 2015 will still have one after the mandate issues.

I. There Will Be at Least Nine Operational Abortion Facilities After the Mandate Issues, and No Area of the State Will Lose Access to Abortions Due to the ASC Requirement.

Defendants are aware of nine abortion facilities that will remain operational after the mandate issues, with a tenth in the process of opening (noted as "pending" in the list below):

1. Planned Parenthood South Austin Clinic	Austin
2. Planned Parenthood of Greater Texas Surgical Health Services	Dallas
3. Southwestern Women's Surgery Center	Dallas
4. Planned Parenthood of Greater Texas Star Clinic	Fort Worth
5. Planned Parenthood Center for Choice	Houston
6. Texas Ambulatory Surgical Center	Houston
7. Whole Woman's Health San Antonio[1]	San Antonio
8. Alamo Women's Reproductive Services	San Antonio
9. Whole Woman's Health of McAllen[2]	McAllen
10. Planned Parenthood South Texas	San Antonio (Pending)

The list of ten facilities Plaintiffs provided in their letter accurately reflects the facilities that were operating as of June 9 but will have to close for not complying with the ASC requirement. *See* Plaintiffs'

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[1] Whole Woman's Health has two abortion facilities in San Antonio—an ASC-compliant facility and a non-ASC-compliant facility. ROA.2467. The former will remain operational and the latter will close if the mandate issues.

[2] The McAllen facility is not ASC-complaint, but will be operational under the Court's ruling, which provided as-applied relief for this facility.

6/12/15 Letter at 2. Nevertheless, no area of the State will lose access to abortion facilities.[3]

Plaintiffs identified one ASC-compliant abortion facility currently in operation that was not included in the parties' stipulations—Alamo Women's Reproductive Services in San Antonio.

Planned Parenthood South Texas is opening a newly constructed ASC-compliant abortion facility in San Antonio. *See* Bruce Selcraig, *S.A. Could Have Three Abortion Clinics After New Law Goes Into Effect*, SAN ANTONIO EXPRESS-NEWS, June 13, 2015, http://bit.ly/1JTBuHX (citing Jeffrey Hons, CEO of Planned Parenthood South Texas, as saying that the abortion provider has "finished construction on a new $6.5 million, 22,000-square-foot clinic" and is now beginning the licensing process). That facility was referenced in the parties' stipulations as being planned. Planned Parenthood is reportedly leasing space from a local ASC to perform abortions until that facility opens. *See* Melissa Fletcher Stoeltje, *Planned Parenthood Will Expand Services With New Center*, SAN ANTONIO EXPRESS-NEWS, Oct. 11, 2014,

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[3] Plaintiffs presented no evidence that closure of some abortion facilities would result in the remaining operational abortion facilities lacking the capacity to perform the number of abortions sought. *See Whole Woman's Health v. Cole*, No. 14-50928, 2015 WL 3604750, at *20 (5th Cir. June 9, 2015) (per curiam) (concluding that there was no evidence that "the current ASCs are operating at full capacity or that they cannot increase capacity").

http://bit.ly/1eiiebL ("Since Sept. 1, when the regulations took effect, Planned Parenthood has leased space at a local surgical center to perform abortions, Hons said.").

II. Plaintiffs' New Arguments Regarding the McAllen Facility Are Untimely and Unfounded.

Plaintiffs raise two new arguments in their June 12 letter to suggest that a stay of the mandate is necessary to keep the McAllen abortion facility operational. Those arguments are waived and meritless.

A. Plaintiffs first assert that if the McAllen abortion facility must comply with unspecified ASC regulations that were not enjoined, that facility will have to close for "an indefinite period of time—likely months." Letter at 2. Plaintiffs' entire support for this proposition is a single, conclusory sentence unsupported by any citation or accompanying evidence (which would be belated and inadmissible in any event): "Among other things, Whole Woman's Health would have to hire and train new nursing staff members; modify many of its existing policies, procedures, and forms; and train its existing staff on those new policies, procedures, and forms." *Id.*

Plaintiffs offered no evidence that the McAllen facility would have to close based on the ASC's nursing or policy regulations, and they never asserted these arguments at trial, on appeal, or even in their recent motion to stay the mandate. *See Whole*

Woman's Health v. Cole, No. 14-50928, 2015 WL 3604750, at *24 (5th Cir. June 9, 2015) (per curiam) ("[W]e are not aware of any record evidence that complying with the nursing requirements would cause the closure of abortion facilities. The Plaintiffs admitted that the remaining operational requirements were comparable to the standards with which abortion facilities were already required to comply.").

These arguments are waived. *See, e.g.*, *Martco Ltd. P'ship v. Wellons, Inc.*, 588 F.3d 864, 877 (5th Cir. 2009) ("arguments not raised before the district court are waived and cannot be raised for the first time on appeal"); *Procter & Gamble Co. v. Amway Corp.*, 376 F.3d 496, 499 n.1 (5th Cir. 2004) (party "waived [an] argument by failing to raise it in its opening brief"); *Lowry v. Bankers Life & Cas. Ret. Plan*, 871 F.2d 522, 525 (5th Cir. 1989) (per curiam) (holding an argument waived because it was not raised on initial appeal).

Plaintiffs' latest refusal to specify which ASC regulations they believe would harm them if the mandate issues is consistent with their longstanding strategy to mount only a generalized attack against the ASC requirement. *See Whole Woman's Health*, 2015 WL 3604750, at *24 (observing that the "Plaintiffs have been careful to avoid identifying which specific portions of the ASC standards contribute to the closure of abortion facilities"). Plaintiffs' approach improperly ignores the severability clauses of both HB2 and the ASC regulations.

Plaintiffs' argument that "it would not be possible" to comply with the ASC regulations before July 1, Letter at 2, has no merit. Plaintiffs have offered no evidence to support this. In fact, the same plaintiff that operates the McAllen facility—Whole Woman's Health—currently operates an ASC abortion facility in San Antonio, presumably in compliance with ASC standards. The plaintiff operating the McAllen facility therefore already has access to its San Antonio facility's policies, procedures, and forms.

Plaintiffs have had multiple bites at the apple to challenge HB2. They cannot raise entirely new as-applied claims regarding McAllen—for which they have no record evidence anyway—in a letter requested by the Court after the appeal has been decided.

B. Plaintiffs' second argument is that the McAllen facility could not operate "to the full extent of patient demand" if the mandate is not stayed because only women from the Rio Grande Valley could obtain abortions there and only one doctor could perform abortions. Letter at 2. That argument is unsubstantiated for several reasons.

First, Plaintiffs offer no evidence that anyone other than women from the Rio Grande Valley obtain abortions at the McAllen abortion facility.

Second, they have no argument for why the injunction should apply to anyone other than women in the Rio Grande Valley. The Court properly limited the injunction to women in the Rio Grande Valley because they were the women that Plaintiffs argued

faced a substantial obstacle to obtaining an abortion due to the closure of the McAllen abortion facility. Plaintiffs cannot now argue that the Court should effectively expand the scope of the injunction based on arguments they never raised.

Third, Plaintiffs' argument that limiting the injunction to only Dr. Lynn prevents them from meeting demand for abortions in McAllen is unfounded. Plaintiffs offered no evidence, argument at trial, or argument on appeal that Dr. Lynn could not meet the demand for abortions at the McAllen abortion facility.

III. The Reopening of an El Paso Abortion Facility Is Unnecessary for the Area to Have Access to Abortions.

Plaintiffs allege that unless the mandate is stayed, Reproductive Services of El Paso—an abortion facility that was not operating on June 9—will be prevented from reopening. Letter at 2-3. Even if that were true, as this Court recognized, "women in El Paso can travel the short distance to Santa Teresa to obtain an abortion and, indeed, the evidence is that many did just that before H.B. 2." *Whole Woman's Health*, 2015 WL 3604750, at *26. Thus, even if the Hilltop Women's Reproductive Clinic in El Paso that was operational on June 9 closes and Reproductive Services of El Paso does not open its new abortion facility, "H.B. 2 does not place a substantial obstacle

in path of those women seeking an abortion in the El Paso area." *Id.*[4]

Conclusion

At least nine abortion facilities in Texas will remain operational after the Court's mandate issues, and a tenth is expected to open soon. No area of Texas that currently has access to abortions will lose access if the Court's mandate issues.

Sincerely,

/s/ Scott A. Keller
Scott A. Keller
Counsel for Appellants

cc: All counsel of record

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[4] Plaintiff Whole Woman's Health also operates an abortion facility in Las Cruces, New Mexico (less than 50 miles from El Paso) that expressly advertises as performing abortions for "women from all over south New Mexico, West Texas, El Paso, and Juarez." WHOLE WOMAN'S HEALTH OF NEW MEXICO, http://wholewomanshealth.com/newmexico/maps-and-directions.html (visited June 15, 2015).